Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #7 PER FH G801 11/08/01 JH

Certificate of Death

Reg. No. 2001 35001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irma F. Small

2. Date of Death: Month 10- Day 29- Year 2001

3. Time of Death: 2:40 A.M.

4a. Facility Name (If not institution, give street and number): Franklin Woods Nursing Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-24-5814

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): ~~84~~ 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12- 13- 1917

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 103 Center Place, Apt. 125

10f. Zip Code: 21222

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Brokerage Firm

17. Fether's Neme (First, Middle, Last): Michael Muransky

18. Mother's Neme (First, Middle, Maiden Surneme): Frances Shuster

19a. Informent's Name/Reletionship (Type, Print): Lois Gregory / Daughter

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 18 Windward Way , Bowleys Quarters, Md. 21220

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): OakLawn Cemetery

Dete: 11-2-01

20c. Location - City or Town, Stete: Balto.,Md.

21. Signeture of Funerel Service Licensee: Robert J Radacky M00937

22. Neme end Address of Fecility: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto.,Md. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death): a. Metastatic Leiomyosarcoma

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last:

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: MD

29c. License number: D53462

29d. Dete signed (Month, Dey, Yeer): 10/29/01

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): JUDE MUNESES MD 7845 Oakwood Road, Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Dey, Yeer): NOV 0 2 2001

32. Registrer's Signeture: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #10e PER FH G801 11/02/01 JH

Certificate of Death

Reg. No. 2001 35002

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Naomi M. Thompson
2. Date of Death: Month 10 Day 20 Year 2001
3. Time of Death: 12:30 a.m.
4a. Facility Name *(If not institution, give street and number)*: 2720 W. Mosher Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-22-0607
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9-3-1921
9. Birthplace *(State or Foreign Country)*: S.C.

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: ~~2730~~ 2720 W. Mosher Street
10f. Zip Code: 21216
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Switchboard Receptionist
16b. Kind of Business/Industry: Hotel

17. Father's Name *(First, Middle, Last)*: Will Thompson
18. Mother's Name *(First, Middle, Maiden Surname)*: Exie Byrant

19a. Informant's Name/Relationship *(Type, Print)*: Geraldine Wilkerson Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2720 W. Mosher Street Baltimore, Md 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oakgrove Missionary Bap
Date: 10-27-01
20c. Location - City or Town, State: Doggett Grove Forest City, N.C.

21. Signature of Funeral Service Licensee: Lynette K. Jones
22. Name and Address of Facility: March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RECURRENT UTERINE CERVIX CANCER-SQUAMOUS — 2 ± YRS

Due to (or as a consequence of):
b. RENAL FAILURE — ± 4 YR.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. INTESTINAL OBSTRUCTION — ± 4 YR

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Buscema, MD
29c. License number: D0025274
29d. Date signed *(Month, Day, Year)*: 10-23-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH BUSCEMA, MD 10755 FALLS ROAD, SUITE 230, LUTHERVILLE MARYLAND 21093

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 0 2 2001
32. Registrar's Signature: Sandra D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

01-5089-510
B.K.S
LARRY R. TUNSTALL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 011102:ITEMS#23a,b,ptII,27 per ME G803 ss

Certificate of Death

Reg. No 2001 35003

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LARRY R. TUNSTALL

2. Date of Death Month Dey Year: SEPT. 7, 2001

3. Time of Death: 8:45 AM

4a. Facility Name (If not institution, give street end number): 3916 RIDGEWOOD AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: UNK

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Feb 13, 1947

9. Birthplece (State or Foreign Country): unk

Usuel Residence of Decedent

10a. Stete: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3916 Ridgewood Avenue

10f. Zip Code: 21215

10g. Citizen of Whet Country?: USA

11. Merital Stetus: unk
1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? unk
1☐ Yes 2☐ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc.
Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): unk

16b. Kind of Business/Industry: unk

17. Father's Neme (First, Middle, Last): unk

18. Mother's Name (First, Middle, Meiden Sumeme): unk

19a. Informent's Neme/Reletionship (Type, Print): O.C.M.E.

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 111 Penn Street Baltimore, MD 21201

20a. Method of Disposition: 1☐ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☒ Other (Specify) in state

20b. Piece of Disposition (Name of cemetery, cremetory or other place):

Dete:

20c. Location - City or Town, State:

21. Signeture of Funerel Service Licensee: Ronald S. Wade, Director

22. Neme end Address of Feciity: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Final diseese or condition resulting in deeth)
e. CARDIAC ARRHYTHMIA

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last
b. MYOCARDIAL HYPERTROPHY

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. Other significant conditione contributing to deeth but not resulting in the underlying ceuse given in Pert I.
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed?
1☑ Yes 2☐ No

24b. Were eutopsy findings aveilable prior to completion of ceuse of death?
1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner?
1☒ Yes 2☐ No

26. Place of Deeth (Check only one)
Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Menner of Death
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify):

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete):

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner es steted.
2☒ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Marguite DeStrelle MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): SEPT. 8, 2001

30. Neme and sddress of person who completed cause of death (Item 23a) (Type, Print): MARY SMITH A. KOREL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year): NOV 0 2 2001

32. Registrer's Signeture: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS#20-22 per fh G801 113001 ss — *Certificate of Death* — Reg. No. 2001 35004

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JUNIOR TINNONS

2. Date of Death: Month October Day 20 Year 2001

3. Time of Death: 1807

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-36-2608

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 28, 1938

9. Birthplace *(State or Foreign Country)*: unk

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 30 S. Athol Avenue

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: unk — 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No — If Yes, Give Year or Dates: unk

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unk — College (1-4or 5+): unk

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unk

16b. Kind of Business/Industry: unk

17. Father's Name *(First, Middle, Last)*: unk

18. Mother's Name *(First, Middle, Maiden Surname)*: unk

19a. Informant's Name/Relationship *(Type, Print)*: St. Agnes Hospital

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 900 Caton Avenue Baltimore, MD 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other *(Specify)* ~~in state~~

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Carmel Cemetery

Date: 11-24-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Daphne Waters ~~Ronald S. Wade, Director~~

22. Name and Address of Facility: Waters Funeral Service, 1216 E Federal St. ~~State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201~~ Baltimore, MD 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. arteriosclerotic cardiovascular disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

seizure disorder, elevated lipids, high blood pressure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Norman Saunders MD

29c. License number: D33061

29d. Date signed *(Month, Day, Year)*: October 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Norman Saunders St Agnes Healthcare Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 0 2 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Timmons, Junior

01-3214-510
jhm
UNK. 01-148

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35005

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): UNKNOWN 01-148
2. Date of Death (Month, Day, Year): JUNE 07, 2001
3. Time of Death: 10:06 AM
4e. Facility Name (If not institution, give street and number): UNIVERSITY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: unk
6. Sex: 1 [X] M 2 [ ] F
7. Age (If yrs. last birthday): unk Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): unk
9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: unk
10b. County: unk
10c. City, Town or Location: unk
10d. Inside City Limits: unk 1 [ ] Yes 2 [ ] No
10e. Street and Number: unk
10f. Zip Code: unk
10g. Citizen of What Country: USA

11. Marital Status: unk
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? unk
1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): unk
College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Neme (First, Middle, Last): unk
18. Mother's Name (First, Middle, Meiden Surneme): unk

19a. Informant's Neme/Relationship (Type, Print): O.C.M.E
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 111 Penn Street Baltimore, MD 21201

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece):
Date:
20c. Location - City or Town, State:

21. Signeture of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. Pneumonia complicating Probable Narcotic Intoxication
Due to (or as a consequence of): And Associated Anoxic Encephalopathy

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Cardiovascular Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? [X] Yes 2 [ ] No
24b. Were eutopsy findings available prior to completion of cause of death? [X] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Date of Injury (Month, Day Year): 5/13/01 (TW)
28b. Time of Injury: 8:34 AM (TW)
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Probable overdose
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Next to railroad tracks
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1300 block Hanover Street Baltimore, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: OCME
29d. Date signed (Month, Day, Year): JUNE 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jack McTigue, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 0 2 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Katie Waters	October 21 2001	11:43 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital center	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
none	1☐ M 2☒ F	Yrs.		1 / 48	Oct 21, 2001	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7419 B Bay Front Road	21219	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
none	none	none	none

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Steven Waters	Betty Wilson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Franklin Square Hospital	9300 Franklin Square Drive Baltimore, MD 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

To Be Completed by Funeral Director

Katie, waters

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Prematurity	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Spontaneous rupture of membranes	
	Due to (or as a consequence of):	
	c. Preterm contractions	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Cicely M Pickett	P14541	10/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Cicely Pickett 9000 Franklin Square Drive Baltimore MD, 21237

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 2 2001	Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35007

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Worrell
2. Date of Death Month Day Year: October 31, 2001
3. Time of Death: 5:00 PM
4a. Facility Name (If not institution, give street and number): 136 N. Edgewood St.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-26-7823
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 2, 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 136 N. Edgewood St.
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse's Assistant
16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): Milton Belton
18. Mother's Name (First, Middle, Maiden Surname): Bertha Mae Worrell

19a. Informant's Name/Relationship (Type, Print): Mrs. Frances Belton
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4217 Roland View Ave. Balto. Md. 21215

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: 11/2/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Congestive heart failure
Due to (or as a consequence of): b. Coronary Arty Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Approximate Interval Between Onset and Death: 5 years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes, Previous Stroke

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rafat Z. Girgis
29c. License number: D31726
29d. Date signed (Month, Day, Year): 11-1-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAAFAT Z. GIRGIS 724 Maiden Choice LA Catonsville

State Registrar

31. Date filed (Month, Day, Year): NOV 0 2 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-6020-003
mnmr
Richard Wagner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#20b,c per fh G802 121101 SS

Certificate of Death

Reg. No. 2001 35008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RICHARD LOUIS WAGNER	October 24, 2001	1448 p M

4a. Facility Name (If not institution, giva straet and number)	4b. City, Town, or Location of Death	4c. County of Death
294 Mt. Ridge Court, Apartment D	Glen Burnie	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Yaar)	9. Birthplace (State or Foreign Country)
216-60-5244	1[X] M 2[ ] F	47 Yrs.					Mar 1, 1954	unk

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Glen Burnie	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
294 Mt. Ridge Court #D	21061	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	truck driver	newspaper

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Wagner	Phyllis Souder

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rita Henry/aunt	957 Hillswood Rd #A Bel Air, MD 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Data	20c. Location - City or Town, State
1[ ] Burial 2[X] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Balto. Wash. Crm.	11/5/01	Laurel, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Intraoral Gunshot Wound	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequance of):	
	d. Due to (or as a consequance of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[✓] No 3[ ] Probably 4[ ] Unknown	1[✓] Yes 2[ ] No	1[✓] Yes 2[ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1[X] Yes 2[ ] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[ ] Natural 2[ ] Accident 3[X] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined	10/24/01	1445 M	1[ ] Yes 2[✓] No	Subject Shot Self
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 294 Mt. Ridge Ct Glen Burnie, Maryland

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1[ ] **Certifying Physician:** To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[X] **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifiar	29c. License number	29d. Date signed (Month, Day, Year)
J. Pestaner M.D.	O.C.M.E.	October 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signatura
NOV 0 2 2001	Penny D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

01-6144-510
mnmr
Darnelle Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35009

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Darnelle	Williams	October 30, 2001	2110 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-98-9683	1 X M 2 F	20 Yrs.			05-02-81	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11 North Bentalou Street	21223	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	X 1 Yes 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th Grade	NA	Never worked	unemployed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Christopher Williams	Sandra Falcon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sandra Williams	11 N. Bentalou Street Baltimore, MD. 21223

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Voshell Mem. Pk.	Cem. 11-07-01	Dundalk, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Two stab wounds to the chest and	
	Due to (or as a consequence of): to the left shoulder	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No 3 Probably 4 Unknown	1 X Yes 2 No	1 X Yes 2 No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 X Homicide 5 Pending investigation 6 Could not be determined	10-30-2001	1707 M	1 Yes 2 X No	subject stabbed

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
alley	100 Block North Central Ave Baltimore City, Maryland

29a. Certifier (Check only one)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted.

X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] Stephen S. Radentz, M.D.	O.C.M.E.	October 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 02 2001	[signature]

DHMH 17 Rev 1/2001

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RF

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35010

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Lest): FRED Wallett

2. Date of Deeth: Month 10 Dey 31 Yeer 01

3. Time of Deeth: 5:20 pm

4a. Feclity Neme (If not institution, give street and number): Genesis-Eldercare Multi Medical Center

4b. City, Town, or Location of Deeth: Towson

4c. County of Deeth: Baltimore

Funeral Director

5. Sociel Security Number: 212-32-6041

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthdey): 68 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Aug 12, 1933

9. Birthplece (State or Foreign Country): Pa.

Usual Residence of Decedent

10e. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 6717 Roberts Avenue

10f. Zip Coda: 21222

10g. Citizan of Whet Country?: USA

11. Marital Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decadent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Raca - American Indien, Bleck, White, etc. Specify: White

15. Decadent's Education (Specify only highest grede completed): Elemantary/Secondary (0-12): 12 yrs. Collaga (1-4or 5+): 7 Yrs.

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Labor Law Specialist

16b. Kind of Business/Industry: Federal Government

17. Fether's Name (First, Middle, Last): Frederick D. Wallett

18. Mother's Neme (First, Middle, Melden Surneme): Mildred T. Nolby

19e. Informent's Neme/Relationship (Type, Print): Nancy Wallett wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6717 Roberts Avenue, Baltimore, Md. 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Nema of cemetery, cramatory or other pleca): Oaklawn Cemetery

Date: Nov. 2, 2001

20c. Location - City or Town, Stete: Dundalk, Md.

21. Signature of Funeral Service Licensee: John E Mills Jr

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failura. List only one ceusa on aach line.

Approximete Intervel Batween Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in death)

a. Failure to Thrive — weeks

Due to (or es e consequenca of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last

b. Multple Sclerosis — years

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other efgnifficant conditfone** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicel exeminer? 1 [ ] Yes 2 [X] No

26. Pleca of Daath (Check only ona)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To tha best of my knowladga, deeth occurred at tha time, data end place, and due to tha causa(s) and manner as stetad. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et tha tima, data and placa, end due to the cause(s) end manner steted.

29b. Signeture and title of certifier: [signature]

29c. License number: D17118

29d. Dete signed (Month, Dey, Yeer): Nov 1, 2001

30. Name and address of person who completed causa of death (Item 23e) (Type, Print): Paul Schwartz M.D 7700 York Rd 21204

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 02 2001

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the buriel-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 35011

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rose D. Arreguin
2. Date of Death Month, Day, Year: October 15, 2001
3. Time of Death: 6:30 PM
4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Nursing Home
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 360-22-5698
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 12, 1912
9. Birthplace *(State or Foreign Country)*: IL

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 15008 Pear Tree Drive
10f. Zip Code: 20721
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerical
16b. Kind of Business/Industry: Financial

17. Father's Name *(First, Middle, Last)*: Thomas J. Nicolette
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Amelio

19a. Informant's Name/Relationship *(Type, Print)*: Al Arreguin/ Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15008 Pear Tree Drive Bowie, MD 20721

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St.Mary's Cemetery
Date: 10-20-01
20c. Location - City or Town, State: Chicago, IL

21. Signature of Funeral Service Licensee: Beall
22. Name and Address of Facility: Beall Funeral Home 6512 NW Crain Hwy Bowie, MD 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — DAYS

Dua to (or as a consaquence of):
b. SENILE DEMENTIA — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 022780
29d. Date signed *(Month, Day, Year)*: 10/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter M Schissler MD 7500 Greenway Ctr Dr. Greenbelt MD 20770

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 2001
32. Registrar's Signature: Sandra B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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DHMH 16 Rev 6/95

ORIGINAL

01-5708-510
B.K.S
FELIX PRINCE'AGBODJAN

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #'s 10g.& 18.Per FH PGC 10-18-01 cr

Certificate of Death

Reg. No. 2001 35012

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FELIX PRINCE AGBODJAN

2. Date of Death Month / Day / Year: OCT. 7, 2001

3. Time of Death: 1300 PM

4a Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 218-41-1924

6. Sex: 1☑M 2☐F

7. Age *(In yrs. last birthday)*: 34 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 1-23-67

9. Birthplace *(State or Foreign Country)*: GHANA

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑Yes 2☐No

10e. Street and Number: 17 WOLFTRAP COURT

10f. Zip Code: 21236

10g. Citizen of What Country? ~~U.S.~~ GHANA

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: RESIDENTIAL COUNSELOR

16b. Kind of Business/Industry: COUNSELLING

17. Father's Name *(First, Middle, Last)*: PRINCE AGBODJAN

18. Mother's Name *(First, Middle, Maiden Surname)*: ~~DOE~~ BELINDA PRINCE

19a. Informant's Name/Relationship *(Type, Print)*: DOREEN PAMELA EFFAH (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17 WOLFTRAP Court BALTO, MD 21236

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☑Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ACCRA CEMETERY

Date: 10-24-01

20c. Location - City or Town, State: ACCRA, GHANA

21. Signature of Funeral Service Licensee: Peter Winfield Jr. 80105

22. Name and Address of Facility: VAUGHN C. GREENE 4905 YORK ROAD BALTIMORE, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary thromboembolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Metastatic Carcinoma

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: OCT. 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 18 2001

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35013

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carolyn F. Ankeney

2. Date of Death (Month, Day, Year): October 16, 2001

3. Time of Death: 4:00 AM M

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 212-46-6979

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03/05/1943

9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Ft. Washington

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 13400 Taylor Court

10f. Zip Code: 20744

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Reed Jesse Moore

18. Mother's Name (First, Middle, Maiden Surname): Hester Loretta Holsberry

19a. Informant's Name/Reletionship (Type, Print): Douglas M. Ankeney / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13400 Taylor Court Ft. Washington, Maryland 20744

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: 10/20/2001

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: George P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Sepsis — 3 days

Due to (or as a consequenca of):

b. Metastatic Carcinoma — 4 years

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Dete of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☑ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B. Reojaee

29c. License number: 039691

29d. Date signed (Month, Day, Year): 10/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. REOJAEE MD, 4467 old Branch Ave Temple Hills, MD

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001

32. Registrar's Signature: Barbara B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ANKENEY

15

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James C Alexander	10-16-01	3:00p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4710 Bethesda Ave #1016	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-50-6232	XX 1☐M 2☐F	62 Yrs.			12-28-38	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Montgomery	Bethesda	1☒Yes XX 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4710 Bethesda #1016	20814	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐Never Married 2☒Married XX 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1/57 2/64	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Montgomery Co Road Works	County Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Shim Green	Rose Timberlake

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Irene Dorsey Alexander	4710 Bethesda Ave#1016 Bethesda Md 20814

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Gates of Heaven	10-20-01	Silver Springs

21. Signature of Funeral Service Licensee: B F Taylor

22. Name and Address of Facility: BF Taylor Funeral Services Inc 1722 North Capitol Street NW

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER	18 MONTH
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as e consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetat death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

ANEMIA

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probebly 4☐Unknown

24e. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ralph Coan M.D.	D011 91	OCT. 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ralph Coan, MD 9618 Culver Street Kensington, Md

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	Sandra G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35015

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Louisa Austin	10	13	01	9:40 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Magnolia Center	Lanham	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
182-26-5509	1☐M 2☒F	94 Yrs.			09-14-07	Wythe, Va.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Bladensburg	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3801 Kenilworth Ave.	20710	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Domestic	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert L. Austin	Phyllis Howard

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Minnie Johnson/ Sister	6513 Clayton Lane, Suitland, MD 20746

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Church Cemetery	10/20/01	West County, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. Wil	JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive CardioVascular Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Dementia — Years.
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gastrostomy Feeding tube

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Rakesh Arora, MD	D 20108	10/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rakesh Arora, MD 14300 Gallant Fox Ln. Bowie, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	Sandra B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35016

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Yinka Adeyefa

2. Data of Death — Month: September Day: 19 Year: 2001

3. Time of Death: 4:50 PM

4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 217-51-3527

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 36 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 16, 1965

9. Birthplace *(State or Foreign Country)*: Nigeria

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 7517 Belgravia Lane

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2 Yrs

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Trader

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Mathew O. Adeyefa

18. Mother's Name *(First, Middle, Maiden Surname)*: Janet Adeyefa

19a. Informant's Name/Relationship *(Type, Print)*: Adeyefa Olasupo/Uncle

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1508 Columbia Ave. Landover, MD 20785

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery

Date: 10/24/01

20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: K. E. W...

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cardio Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. AIDS

Due to (or as a consequence of):
c. Sepsis

Due to (or as a consequence of):
d. Renal Failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ... MD

29c. License number: D 42019

29d. Date signed *(Month, Day, Year)*: 09-24-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Imran Chowdhury 5632 Annapolis Rd. Suite 13 Bladensburg, MD 20710

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001

32. Registrar's Signature: ... B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35017

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
CHERYL J. BROWNE	October 7, 2001	7:40 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FORT WASHINGTON HOSPITAL	FORT WASHINGTON	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-90-6948	1☐M 2☒F	40 Yrs.					Sept 29 1961	Wash., DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Prince George's	Fort Washington	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13516 Reid Circle	20744	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	1	Legal Secretary	Secretarial

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph C. Browne, Jr.	Shirley Vaughn

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley Browne / Mother	13516 Reid Circle Ft. Washington, Md 20744

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lincoln Memorial Cem.	10-11-01	Suitland, Md.

21. Signature of Funeral Service Licensee: Larry Cubbage

22. Name and Address of Facility: Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)	a. INTRA ABDOMINAL HEMORRHAGE	HOURS
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as e consequence of): MALIGNANT OVARIAN CHORIOCARCINOMA	MONTHS
	c. Due to (or as e consequence of):	
	d. Due to (or es a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpetient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
[signature]	D32800	Oct. 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hilary Washington, M.D. 11701 Livingston Rd. Ste.205 Ft. Wash., MD

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

01-5665-033
crn
Christopher Bidgell

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christopher McKinley Bidgell

2. Date of Death: Month October Dey 04 Year 2001

3. Time of Death: 2:45 P.M.

4a Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-06-7885

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 18 Yrs.

If Under 1 Year: Months Days

If Under 24 Hrs.: Hours Min.

8. Date of Birth (Month, Day, Year): 01-25-1983

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2517-B Kenttown Place

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Christopher McKinley Springer II

18. Mother's Name (First, Middle, Maiden Surname): Melita Bidgell

19a. Informant's Name/Relationship (Type, Print): Melita Bidgell/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2517 B Kenttown Place Landover, MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Cemetery

Date: 10-15-01

20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: ▶ K. E. W

22. Name and Address of Facility: JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple gunshot wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b.

Due to (or es a consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 10-04-2001

28b. Time of Injury: 1406 P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Subject was shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): 6868 Hawthorne Street Prince Georges County, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ Stephen S. Radentz, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): October 05, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 16 2001

32. Registrer's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

OCT 18 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35019

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Millicent Bisnath

2. Date of Death: Month 10 Day 11 Year 01

3. Time of Death: 1:35 pm

4a. Facility Name (If not institution, give street and number): Sacred Heart Home, Inc.

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 230-11-5922

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 2, 1916

9. Birthplace (State or Foreign Country): Trinidad, W.I.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5805 Queens Chapel Road

10f. Zip Code: 20782

10g. Citizen of What Country?: Trinidad

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamtress

16b. Kind of Business/Industry: self-employed

17. Father's Name (First, Middle, Last): Charles Pierre

18. Mother's Name (First, Middle, Maiden Surname): Elnora Pierre

19a. Informant's Name/Reletionship (Type, Print): Buss Bisnath/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 117 Hamilton Rd. Sterling, Virginia 20165

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

Date: 10/13/01

20c. Location - City or Town, State: Wash.,DC

21. Signature of Funeral Service Licensee: W. J. Jeffrie

22. Name and Address of Facility: Frazier's Funeral Home, Inc. 389 R.I. Ave.,N.W. Wash.,DC 20001

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. INANITION — 2 weeks

Due to (or as a consequence of):

b. multi infarct dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end ptece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Peter M Schissler MD

29c. License number: D22730

29d. Date signed (Month, Day, Year): 10/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter M Schissler MD 7506 Greenway Ctr Dr. Greenbelt, Md. 20770 7500 Greenway Ctr. Dr. #430 Greenbelt,Md

State Registrar

31. Date filed (Month, Day, Year): OCT 16 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

OCT 15 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35020

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: John N. Blake Sr.

2. Dete of Deeth — Month: October; Day: 12; Yaar: 2001

3. Time of Death: 2:20 PM

4e. Facility Name *(If not institution, give straat and number)*: Magnolia Garden Nursing Home

4b. City, Town, or Location of Deeth: Lanham, MD

4c. County of Daath: Prince Georges

Funeral Director

5. Sociel Security Numbar: 212-14-0521

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. lest birthday)*: 84 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Dete of Birth *(Month, Dey, Year)*: July 21, 1917

9. Birthplece *(Stata or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stete: MD

10b. County: Prince Georges

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Numbar: 1800 Mitchellville Rd

10f. Zip Code: 20721

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U,S. Armad Forces? 1☒ Yes 2☐ No If Yes, Giva Yaar or Dates:

13. Was Dacedent of Hispenic Orlgin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Raca - Amarican Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Warrant Clerk

16b. Kind of Business/Industry: Government

17. Father's Neme *(First, Middle, Lest)*: Richard E. Blake

18. Mother's Name *(First, Middle, Maiden Sumame)*: Ethel Jones

19e. Informent's Neme/Reletionship *(Type, Print)*: Millicent Blake/Wife

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 1800 Mitchellville Rd Mitchellville, MD 20721

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Jones Memorial Cemetery

Date: 10-18-01

20c. Location - City or Town, Stete: Mitchellville, MD

21. Signature of Funeral Service Licensee: ▶ K. E. Wil

22. Name end Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the diseasa, or complicetions that caused the deeth. Do not enter tha moda of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximata Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in daath)

e. Pneumonia — Due to (or es e consequenca of):

Approximata Intervel Between Onset end Deeth: 2weeks.

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b. — Due to (or es e consequence of):

c. — Dua to (or as e consaquanca of):

d.

Part II. **Other eignificant conditione** contributing to death but not resulting in tha underlying cause given in Part I.

Parkinson's Disease

23b. **Did tobacco uee contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yas 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Rasidence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: ▶

29c. License number: D47063

29d. Date signed *(Month, Dey, Yeer)*: 10/16/01

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): William DeBoyce, MD 4000 Mitchellville Rd B216 Bowie, MD 20715

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

(10)

State Registrar

31. Dete filed *(Month, Dey, Year)*: OCT 18 2001

32. Registrer's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35021

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MOSES WILSON BROWN

2. Date of Death Month Day Year: OCTOBER 14, 2001

3. Time of Death: 11:00AM

4a. Facility Name (If not institution, give street and number): 13211 GREENMOUNT AVE.,

4b. City, Town, or Location of Death: BELTSVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 244-20-4697

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6/30/1923

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD

10b. County: PRINCE GEORGES

10c. City, Town or Location: BELTSVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1321 GREENMOUNT AVE.,

10f. Zip Code: 20705

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BAKER

16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): JAMES BROWN

18. Mother's Name (First, Middle, Maiden Surname): ROBERTA MILLS

19a. Informant's Name/Relationship (Type, Print): MARTHA BROWN - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13211 GREENMOUNT AVE, BELTSVILLE, MD 20705

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FT LINCOLN

Date: 10/17/01

20c. Location - City or Town, State: MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST, NW, WASHINGTON DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dementia — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alzheimer Disease — 1 year

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular disease

Chronic anemia

Chronic obstructive pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D26707

29d. Date signed (Month, Day, Year): 10-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TUNG-pi Lee, MD 700 Buckingham Drive. Silver Spring MD 20901

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001

32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35022

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura Lemon Jones Barber

2. Date of Death (Month, Day, Year): October 13, 2001

3. Time of Death: 1:20 P.M.

4a. Facility Name (If not institution, give street and number): Prince Georges Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 224-28-2220

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 17, 1921

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Capitol Heights

10d. Inside City Limits: ☒Yes 2☐No

10e. Street and Number: 1207 Addison Road South; Apt. 445

10f. Zip Code: 20743

10g. Citizan of What Country?: United States

11. Marital Status: 1☐Nevar Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 1 year

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Computer Operator

16b. Kind of Business/Industry: U.S. Dept. of Navy Naval Research Lab.

17. Father's Name (First, Middle, Last): Robert Jones

18. Mother's Name (First, Middle, Maiden Sumama): Kate Williams

19a. Informant's Name/Reletionship (Type, Print): Darryl Renee Jones (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 11307 Kettering Terrace;Upper Marlboro,Maryland 20774

20a. Method of Disposition: 1☒Buriel 2☐Cramation 3☐Removel from State 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Lincoln Memorial Cemetery

Date: Oct. 20,2001

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funarel Service Licanse: Gregory O. Dobbins

22. Nama and Address of Facility: R. N. Horton Company Morticians, Inc. 600 Kennedy Street,N.W.;Washington,D.C. 20011

Physician /Medical Examiner

24a. Part I. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only ona cause on each line.

Approximate Interval Between Onset and Daath

Immediate Cause (Final disaasa or condition resulting in deeth):

a. Cardiogenic Shock

Dua to (or as e consequence of):

Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b. Azotemia

Due to (or es a consequence of):

c. Multiple Organ Failure

Due to (or as a consequence of):

d. Metastatic Gastric Cancer

IF FEMALE:

23b. Was decedent pregnent in the pest 12 months? 1☐Yas 2☒No 9☐Unknown

23c. If yes, outcome of pregnency: 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown

23d. Dete of delivery: Month Day Year

Part II. **Othar significant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to compiation of causa of death? 1☐Yas 2☐No

25. Was casa rafarred to madical axaminar? 1☐Yes 2☒No

28. Placa of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☒**Certifying Physician:** To the best of my knowledga, death occurred et the time, date and place, and due to the cause(s) end manner es steted. 2☐**Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, data and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Willie C Blair, M D

29c. License number: D21891

29d. Date signed (Month, Day, Year): October 16, 2001

30. Nama and address of person who completed causa of deeth (Item 23a) (Type, Print): Willie C. Blair, M.D.; 7525 Greenway Center Drive,Suite 211;Greenbelt, Maryland 20770

State Registrar

31. Data filad (Month, Day, Yaar): OCT 19 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35023

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Harry Levern Bell	October 17 2001	0355 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-54-3694	1☒M 2☐F	51 Yrs.			Oct. 26, 1949	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Washington	Hagerstown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13031 Pinehill Dr.	21740	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Finisher	Dry Wall

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Rex L. Bell	Helen Whitesell

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rebecca L. Stuller (Sister)	115 Antioch Lane Falling Waters, WV. 25419

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Smithsburg Crematory	Oct. 18 2001	Smithsburg, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dennis K. Davis	Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert feilure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in death)	a. Cirrhosis of Liver	years
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last	Due to (or as a consequence of): b. End Stage Hepatic Disease	years
	Due to (or es e consequence of): c. Hyperammonemia	years
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Wes decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnent et time of deeth 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probebly 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Jill Ciccarelli	MD0052136	10/17/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ciccarelli 6 Byrkit Dr. Williamsport, Md. 21795

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
OCT 22 2001	▶ D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Bell, Harry Levern

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35024

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES MARTIN BARTLETT
2. Date of Death: Month OCTOBER Day 21, Year 2001
3. Time of Death: 1630
4e. Facility Name *(If not institution, give street and number)*: FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 215-42-3263
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 23, 1943
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: KNOXVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 18101 MORGAN PINE ROAD
10f. Zip Code: 21758
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: OWNER/OPERATOR
16b. Kind of Business/Industry: ANTIQUES
17. Father's Name *(First, Middle, Last)*: JOHN BURGESS BARTLETT, SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: MAMIE VIOLA EYLER
19a. Informant's Name/Relationship *(Type, Print)*: DARLENE BARTLETT, WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18101 MORGAN PINE ROAD, KNOXVILLE, MD 21758
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SAMPLES MANOR CEMETERY
Date: OCT. 24, 2001
20c. Location - City or Town, State: SHARPSBURG, MARYLAND
21. Signature of Funeral Service Licensee: Kelly A. Zimmerman
22. Name and Address of Facility: BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Severe End Stage COPD — 10 yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D21944
29d. Date signed *(Month, Day, Year)*: 10/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jane S. Grimm MD 300 W 9th St. Frederick, Md. 21701

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 23 2001
32. Registrar's Signature: Brenda Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

01-5556-031
crn
Edgar M. Canales

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 copy

Certificate of Death

Reg. No. 2001 35025

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edgar M. Canales
2. Date of Death (Month, Day, Year): September 29, 2001
3. Time of Death: 3:52 A.M.
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-37-5166
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 30 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-9-71
9. Birthplace (State or Foreign Country): El Salvador

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 7402 18th Avenue
10f. Zip Code:
10g. Citizen of What Country? El Salvador

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify: El Salvador
14. Race - American Indian, Black, White, etc. Specify: White(Hispanic)

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Carpet Installation

17. Father's Name (First, Middle, Last): Carlos Sebastian Chavez
18. Mother's Name (First, Middle, Maiden Surname): Maria De Los Angeles Canales

19a. Informant's Name/Relationship (Type, Print): Juan Carlos Canales
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7402 18th Avenue Hyattsville, Maryland

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cem.
Date: 10/13/01
20c. Location - City or Town, State: Aldephi, Maryland

21. Signature of Funeral Service Licensee: Roger L Mason
22. Name and Address of Facility: Sterling Funeral Service 1601 Kenilworth Ave NE Wash DC 20019

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SMOKE AND SOOT INHALATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 9-29-01
28b. Time of Injury: ~0300 AM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: INHALED SMOKE IN A HOUSEFIRE
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 7402 HYATTSVILLE 18th AVENUE P.G. COUNTY MD

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wayne Ineichen MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): September 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARRY P. A. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 17 2001
32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

(1)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35026

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James M. Creek	October 11, 2001	10:46 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-58-9219	1 XX M 2 F	56 Yrs.			September 19, 1945	Washington, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Hyattsville	1 XX Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2704 Hawthorne Terrace	20785	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 XX Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Press Operator	Federal Government (Retired)
	2		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Creek	Viola A. Branham

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Francine S. Creek (Wife)	2704 Hawthorne Terrace Hyattsville, Maryland 20785

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Maryland Veteran's Cemetery	10/18/01	Cheltenham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
ROLLINS FUNERAL HOME, INC.
4339 HUNT PLACE, N.E. Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Asystoly
Due to (or as a consequence of):
b. Alcoholic Liver Disease
Due to (or as a consequence of):
c. Hypertension
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 XX No

25. Was case referred to medical examiner? 1 Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 X Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0054794	10/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Dereje Z. Haile 6005 Londonderry Dr. Suitland, Md 20706

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 2001	Bonnie B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35027

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John F. Copes Jr.
2. Date of Death (Month, Day, Year): October 14 2001
3. Time of Death: 1005
4a. Facility Name (If not institution, give street and number): 3820 Copperville Way
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 077-34-8883
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 5, 1942
9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md
10b. County: Prince Georges
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3820 Copperville Way
10f. Zip Code: 20748
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Carrier
16b. Kind of Business/Industry: U.S. Postal Service

17. Father's Name (First, Middle, Last): John F. Copes
18. Mother's Neme (First, Middle, Maiden Surname): Justine W. Hartman

19a. Informent's Name/Relationship (Type, Print): Pheoris H Copes (Wife)
19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 3820 Copperville Way Fort Washington Maryland 20748

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Fort Hill Cemetery
Date: 10-20
20c. Location - City or Town, State: Auburn New York

21. Signeture of Funeral Service Licensee: Phillip Ball
22. Neme and Address of Facility: Lewis Funeral Home 311 N. Patrick St. Alex, Va 22314

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finai disease or condition resulting in death): a. Atherosclerotic Cardiovascular Heart Disease

Due to (or es e consequenca of):

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es e consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Piece of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es steted. 2 ☒ **Medical Examiner:** On the besis of exemineticn and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: Salvador Sylvester, DO
29c. License number: H00055927
29d. Date signed (Month, Dey, Yeer): October 17, 2001

30. Name and address of person who completed cause of deeth (Item 23e) (Typa, Print): Salvador Sylvester, DO 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001
32. Registrar's Signature: Barbara A. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(10)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEAN CONWAY

2. Date of Death (Month, Day, Year): OCTOBER 12TH 2001

3. Time of Death: 1:25 PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE.

Funeral Director

5. Social Security Number: 213-36-2000

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 11, 1940

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE MD.

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 202 NORTH FREEMONT AVENUE

10f. Zip Code: 21201

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRESSER

16b. Kind of Business/Industry: CLEANERS/ CLOTHES

17. Father's Name (First, Middle, Last): JOHN CONWAY

18. Mother's Name (First, Middle, Maiden Surname): LORRAINE ALLEN CONWAY

19a. Informant's Name/Relationship (Type, Print): BARBARA COLE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3835 LABYRINTH ROAD BALTIMORE MD. 21215

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ALLEN FAMILY CEMET

Date: 10/20/01

20c. Location - City or Town, State: SENORA VA.

21. Signature of Funeral Service Licensee: ▶ B. O. Waddy

22. Name and Address of Facility: BERRY O. WADDY 6784 MARYBALL ROAD LANCASTER VA. 22503

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. OVARIAN CANCER.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

CORONARY ARTERY DISEASE.

HYPERTENSION.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: ▶ D Harish

29c. License number: D 42723.

29d. Date signed (Month, Day, Year): OCTOBER 12TH 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AYYERAHALLI M HARISH. NORTHWEST HOSPITAL CENTER 5401 OLD COURT ROAD. MD 21133.

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001

32. Registrar's Signature: Sandra G. Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 35029

CHERBA, JOANNA 577528345

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOANNA MAE CHERBA
2. Date of Death Month / Day / Year: October 21 2001
3. Time of Death: 10:50PM
4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 577-52-8345
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 16, 1939
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Ocean City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: #9 144th St.
10f. Zip Code: 21842
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Denzel Noland
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna LaCourt

19a. Informant's Name/Relationship *(Type, Print)*: Brenda A. Tighe
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6318 Newburn Dr., Bethesda, Md. 20816

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cape Henlopen Crematory
Date: 10-23-01
20c. Location - City or Town, State: Frankford, Delaware

21. Signature of Funeral Service Licensee: Harvey Henderson 100784
22. Name and Address of Facility: The Burbage Funeral Home, 108 William st., Berlin, Md. 21811

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cirrhosis of LIVER — YEARS

Due to (or as a consequence of):
b. Gastrointestinal Bleeding — 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

TOD - 2250 10/21/01

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D047676
29d. Date signed *(Month, Day, Year)*: 10/22/01

ET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 12 BSHOR TOULEMAT 9733 HIGHWAY Dr Berlin MD 21811

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 23 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35030

COTTERMAN, NEIL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): NEIL SANDERS COTTERMAN

2. Data of Death: Month OCTOBER Day 18 Yaer 2001

3. Tima of Death: 1:10 A.M.

4a Facility Name (If not institution, give street and number): Berlin Nursing and Rehabilitation Center

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

5. Social Security Number: 217-78-9594

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 41 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Year): 3/21/1960

9. Birthplace (Steta or Foreign Country): MD

Usual Residence of Decedent

10a. Stete: MD

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 203 E. Market St.

10f. Zip Code: 21863

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Consumer

16b. Kind of Business/Industry: Developmental Center

17. Father's Nema (First, Middle, Last): Harold F. Cotterman, Jr.

18. Mother's Name (First, Middle, Meiden Sumeme): Willa Sanders

19a. Informent's Neme/Reletionship (Type, Print): Mary Ann Ross/ Sister

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 9432 Cropper Island RD Newark, MD 21841

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Steta 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Pine Grove Cemetery

Date: 10/22/01

20c. Location - City or Town, Stata: Mt. Airy, MD

21. Signature of Funeral Service Licensee: W. Bud Burbage

22. Name end Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not anter tha moda of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in death):
a. Hepatic Encephalopathy — 2 wks

Due to (or as a consequence of):
b. Hepatic Cirrhosis — 5 yrs

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last:
c. Hepatitis B, chronic — 5 yrs

Dua to (or es a consequance of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

End Stage Renal Disease

Downs Syndrome

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify):

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or invastigetion, in my opinion, death occurred et the tima, data and place, end due to the ceuse(s) end menner steted.

29b. Signature end titla of certifier: Gregorio M. Belloso M.D.

29c. Licensa number: D 29505

29d. Date signed (Month, Dey, Year): 10-19-2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

ET 3

State Registrar

31. Dete filed (Month, Day, Year): OCT 19 2001

32. Registrar's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 35031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUNIOR LEE COOK
2. Date of Death (Month, Dey, Year): October 15, 2001
3. Time of Death: 1:50 P.M.
4a. Facility Name (If not institution, give street and number): Avalon Manor Health Care Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 174-01-3756
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 17, 1918
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 346 South Locust Street
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Manufacture of Vending Machines

17. Father's Name (First, Middle, Last): Paul Evert Cook
18. Mother's Name (First, Middle, Maiden Surname): Mary K. O'Lee

19a. Informant's Name/Ralationship (Type, Print): Donna Jean Beard Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 246 South Locust Street, Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): Green Hill Cemetery
Date: 10-18-2001
20c. Location - City or Town, State: Waynesboro, Pennsylvania

21. Signature of Funeral Service Licensee: ▶ R. Noel Brady
22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in daath) a.	CHRONIC OBSTRUCTIVE LUNG DISEASE	35Y
Due to (or as a consequenca of): b.	CONGESTIVE HEART FAILURE	15Y
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	PERIPHERAL VASCULAR DISEASE	10Y
d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributs to tha causs of death? 1☐ Yss 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona)
Hospital: 1☐ Inpatient 2☐ ER/Outpatiant 3☐ DOA
Other: 4☒ Nursing Homa 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D52323
29d. Date signed (Month, Day, Year): 10/16/01

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): DR. KHALID WASEEM 19414 C LEITERSBURG PIKE HAGERSTOWN, MD 21742

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001
32. Registrer's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Junior Cook 10-15-01 @ 150pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35032

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Donald Lee Cole	October 21 2001	9:10 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
209 South Conococheague Street	Williamsport	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-24-2175	XX M 2☐ F	73 Yrs.			Sept. 9, 1928	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Williamsport	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
209 South Conococheague Street	21795	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	XX 1☐ Yes 2☐ No 1945-1949	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Shipper	Parts Automobile Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Bruce Lawford Cole	Anna May Schetrompf

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gloria V. Cole - Wife	209 South Conococheague St. Williamsport, MD 21795

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Greenlawn Mem. Park	10-24-01	Williamsport, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gastric Lymphoma	weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. 8 cm Left Upper Lobe Lung Mass	weeks
	Due to (or as a consequence of): c. Anemia	week
	Due to (or as a consequence of): d. Gastrointestinal Bleeding	weeks

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Tobacco Abuse

23e. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
[signature]	MD0052136	October 22, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Jill Ciccarelli 3 Byrkit Dr Williamsport MD 21795

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
OCT 23 2001	[signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35033

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALICE FLORETTA COFFMAN
2. Date of Death Month Day Year: Oct. 21, 2001
3. Time of Daath: 10:05 AM
4a. Facility Name *(If not institution, give street and number)*: 1219 Virginia Avenue
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington Co.

Funeral Director

5. Social Security Number: 219-14-9680
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 1, 1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1219 Virginia Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decadant Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Sandblasting Equip. Mfg.

17. Father's Name *(First, Middla, Last)*: Norman Scott Snook
18. Mothar's Nama *(First, Middla, Maiden Sumama)*: Eva Virginia Startzman

19a. Informant's Name/Relationship *(Type, Print)*: Marshall E. Coffman/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Coda)*: 1219 Virginia Avenue, Hagerstown, Maryland 21740

20a. Mathod of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenlawn Mem. Park
Date: Oct.24,2001
20c. Location - City or Town, State: Williamsport, Maryland

21. Signature of Funeral Service Licensee: Douglas A Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaase or condition resulting in death): a. Respiratory failure — minutes

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Metastatic Cancer to Lungs — months
c. Due to (or as a consequence of): Uterine Cancer — months
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yas 2☐No 9☐Unknown
23c. If yes, outcoma of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Other *(specify)* _____ 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yas 2☐No

25. Was casa refarred to madical examinar? 1☐Yes 2☒No

28. Placa of Daath *(Chack only ona)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 8☐Othar *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Panding investigation 6☐Could not be datermined

28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐Yas 2☐No
28d. Describe how injury occurred
28a. Place of tnjury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martin W. Gallagher Jr. MD
29c. License number: D003 1880
29d. Date signed *(Month, Day, Year)*: 10/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARTIN W. GALLAGHER, JR., M.D. Robinwood Med Ctr. Hagerstown

State Registrar

31. Date filed *(Month, Day, Yaar)*: OCT 2 4 2001
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35034

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Jade Clark

2. Date of Death (Month, Day, Year): Oct. 21 2001

3. Time of Death: 7:35 Am

4a. Facility Name (If not institution, give street and number): Western Maryland Hospital Center

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-15-2081

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 15 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 4, 1986

9. Birthplace (State or Foreign Country): Korea

Usual Residance of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: ☒ Yes 2☐ No

10a. Street and Number: 67 Broadway # 1

10f. Zip Code: 21740

10g. Citizen of What Country? U.S.A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: Asian

15. Decedent's Education (Specify only highast grada complated): Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Dennis Matthew Clark

18. Mother's Name (First, Middle, Maiden Surnama): Deborah Karen Wright

19a. Informant's Name/Relationship (Type, Print): Deborah K. Clark (Mother)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 67 Broadway #1 Hagerstown, Md. 21740

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or other place): Smithsburg Crematory

Data: Oct. 22, 2001

20c. Location - City or Town, Stata: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis

22. Nama and Address of Facility: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complicetions that caused the deeth. Do not entar the mode of dying, such es cardiac or respiratory arrest, shock, or haart failura. List only ona causa on eech lina.

Approximeta Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. ARTERIOVENOUS MALFORMATION BRAIN. — 54 yrs.

Due to (or as a consequence of):

b. INTRAVENTRICULAR. HEMORRHAGE. — 6 weeks.

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mennar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determinad

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, deeth occurred at the tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Maryen g map

29c. License number: D28365

29d. Data signed (Month, Day, Year): 10-21-01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANZAR. J. SHAH. 1500 Pennsylvania Avenue Hagerstown, MD 21742

State Registrar

31. Dete filed (Month, Day, Year): OCT 23 2001

32. Registrar's Signatura: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35035

NAME KNOWN TO PHYSICIAN: DAWLEY, JOHN

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
John Dawley, Jr.	OCTOBER 14 2001	7:45PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
VA MARYLAND HEALTHCARE SYSTEM	PERRY POINT	CECIL

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-32-2998	1☒ M 2☐ F	74 Yrs.			May 6, 1927	Wash., DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Clinton	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6815 Danford Drive	20735	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Printing Supervisor	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Nama (First, Middle, Maiden Sumama)
John Dawley, Sr.	Rose (Unknown)

19a. Informant's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Sylvia Dawley-Wells - Daughter	6815 Danford Dr., Clinton, MD 20735

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	Mt. Olivet Cemetery	10/20/2001	Wash., DC

21. Signature of Funeral Service Licensee	22. Name end Address of Feciility
▶ John T. Stewart, III	Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failura. List only one cause on each lina.

		Approximete Interval Between Onset end Death
Immediete Cause (Finel disease or condition resulting in death)	e. PNEUMONIA	UNKNOWN
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of deeth?
1☒ Yes 2☐ No	1☐ Yes 2☒ No

25. Wes case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mennar as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the tima, data and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶	D42800	10-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS BIONDO, VAMARYLAND HEALTHCARE SYSTEM, PERRY POINT, MD 21902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 18 2001	▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 35036

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Edward Dement
2. Date of Death Month Dey Year: October 18, 2001
3. Time of Death: 5:45 am
4a. Facility Name *(If not institution, give street and number)*: St. Agnes Nursing & Rehabilitaiton Center
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 579-40-6951
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 5, 1933
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4609 Queensbury Road
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1956-1958
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Restaurant Owner
16b. Kind of Business/Industry: Private Business

17. Father's Name *(First, Middle, Last)*: James Edward Dement, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah McMullen

19a. Informant's Name/Relationship *(Type, Print)*: Julie L. Dement - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2535 Old Frederick Road, Catonsville, MD 21228

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 10/22/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Dudley Dean Wirt
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequance of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datermined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Tasneem Lakham
29c. License number: D 28595
29d. Date signed *(Month, Day, Year)*: 10/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHAM, 7220 PARK HEIGHTS AVE BALTO MD 21208

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001
32. Registrar's Signature: Sandra G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be axcuted within 24 hours after death.
To the Funeral Director: After this cartificate has been signed by the attanding physician and completely filled in by tha funeral director, paga 2 should be detached for use as tha burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35037

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian Deal

2. Date of Death (Month, Day, Year): October 14, 2001

3. Time of Death: 2:45 A M

4a. Facility Name (If not institution, give street and number): 1916 Columbia Ave.

4b. City, Town, or Location of Death: Landover

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-70-5062

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 11, 1951

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1916 Columbia Ave.

10f. Zip Code: 20785

10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Postal Worker

16b. Kind of Business/Industry: Government

17. Fether's Name (First, Middle, Last): John Henry Deal

18. Mother's Name (First, Middle, Maiden Surname): Louise White

19a. Informant's Name/Reletionship (Type, Print): Joyce Tyler/Sister

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1916 Columbia Ave. Landover, MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cem.

Dete: 10/20/2001

20c. Location - City or Town, Stete: Brentwood, MD

21. Signature of Funeral Service Licensee: K.E. Wil

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death)

a. Non-Small Cell Lung Cancer

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Brain Metastasis

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the pest 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnency: 1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnancy 4☐ Pregnent et time of daeth 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probebly 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Gaskins, MD

29c. License number: D43162

29d. Date signed (Month, Dey, Yeer): 10/18/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Melvin Gaskins 12164 Central Ave. Suite 220 Mitchellville, MD 20721

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001

32. Registrar's Signature: Sandra G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

(2)

OCT 19 2001

Amended
Item#8/SC/WCHD
Per FH/10-24-2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35038

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
CHARLES WARREN DEMMITT	October 19, 2001	6:56 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-16-2108	1☒M 2☐F	74 Yrs.			~~June 27~~, June 11, 1927	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington Co.	Hagerstown	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
55 Mealey Parkway	21742	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Owner	Plumbing & Heating

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Leroy Demmitt	Hazel Eichelberger

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia E. Demmitt/Wife	55 Mealey Parkway, Hagerstown, Maryland 21742

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rest Haven Cemetery	Oct. 22	Hagerstown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Douglas A Fiery	Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RENAL FAILURE	1 WEEK
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. BILATERAL URETERAL OBSTRUCTION	1 WEEK
	Due to (or as a consequence of): c. ADVANCED TRANSITIONAL CELL CARCINOMA	1990
	Due to (or as a consequence of): d. OF BLADDER	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DEMENTIA

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
FAMILY PHYSICIAN	D17067	10/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN E. MEERWEIN, MD 747 NORTHERN AVE HAGERSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 24 2001	Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Demmitt, Charles Warren 003 06/11/1927 Time of Death 6:56 AM 10/19/01

NAME: DEMMITT,CHARLES WARREN
06/11/1927 74 / M

DOS: 10/15/2001
METZNER,STEPHEN E.

H3043665904

H291032

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35039

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DENVER S. DEHAVEN

2. Date of Death: Month OCTOBER Day 13 Year 2001

3. Time of Death: 0920

4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 232-36-6806

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 23 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): 1/26/1978

9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: WV

10b. County: BERKELEY

10c. City, Town or Location: BUNKER HILL

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 345 CURRENCY DRIVE

10f. Zip Code: 25413

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 11; College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PAINTER

16b. Kind of Business/Industry: COMMERCIAL

17. Father's Name (First, Middle, Last): DANE S. DEHAVEN

18. Mother's Name (First, Middle, Maiden Surname): CONNIE ROBINSON

19a. Informant's Name/Relationship (Type, Print): SABRINA DEHAVEN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 345 CURRENCY DRIVE, BUNKER HILL, WV 25413

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. VIEW CHURCH CEMETERY

Date: 10/16/01

20c. Location - City or Town, State: RFD BUNKER HILL, WV

21. Signature of Funeral Service Licensee: ▶ Charles M Brown

22. Name and Address of Facility: BROWN FUNERAL HOME, 327 W. KING STREET, P.O. BOX 821, MARTINSBURG, WV 25402

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Closed Head Injury and Multiple — 12hr.

Due to (or as a consequence of):
Trauma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ____

Due to (or as a consequence of):
c. ____

Due to (or as a consequence of):
d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Multi Drug Abuse

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): OCT 12, 2001

28b. Time of Injury: 2000 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Automobile Accident

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): East Moler Ave. Martinsburg, W.Va.

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Edward W. DiHo III (M)

29c. License number: DO-1062

29d. Date signed (Month, Day, Year): Oct 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward W. DiHo II (M) 19,011 orchard ten. Rd. Hagerstown, Md 21742

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): OCT 24 2001

32. Registrar's Signature: ▶ B Spencer

DHMH 16 Rev 6/95

ORIGINAL

01-5701-033
B.K.S
MINNIE STEWART EXUM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35040

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Minnie Stewart Exum

2. Date of Death (Month, Day, Year): OCT. 7, 2001

3. Time of Death: 0517 AM

4a. Facility Name (If not institution, give street and number): 2200 RITCHIE ROAD

4b. City, Town, or Location of Death: FORRESTVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 212-62-2394

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): Nov. 15, 1952

9. Birthplace (State or Foreign Country): Lexington, KY

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Prince George

10c. City, Town or Location: Largo

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10809 Joyceton Court

10f. Zip Code: 20774

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, Whita, atc. Specify: Black

15. Decedent's Educetion (Specify only highest grada completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 3

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Accountant

16b. Kind of Business/Industry: Private

17. Fathar's Name (First, Middle, Last): Clarence Stewart

18. Mother's Neme (First, Middle, Maiden Surneme): Katherine Jones

19a. Informent's Neme/Reletionship (Type, Print): Larry Exum/Spouse

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 10809 Joyceton Ct.Largo, MD. 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or othar place): Harmony Memorial Park

Date: 10/13/01

20c. Location - City or Town, Stete: Landover, MD.

21. Signeture of Funerel Service Licensee: Ava J. Mikell

22. Name and Addrass of Facility: Pope Funeral Homes, 5538 Marlboro Pike, Forestville, MD. 20747

Physician /Medical Examiner

23a. Pert1. Enter the Causa, or complications thet caused the daath. Do not enter the moda of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximele Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in deeth)

e. Head and Chest Injuries

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☒ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☒ Yes 2☐ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Menner of Deeth: 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Yeer): 10/7/01

28b. Time of Injury: 0458 M

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Driver in auto accident

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete): 2200 Blk. Ritchie Rd.

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☒ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier:

29c. Licensa number: O.C.M.E

29d. Data signed (Month, Dey, Year): OCT. 7, 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 15 2001

32. Registrer's Signeture: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

OCT 15 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35041

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jayne Elizabeth Fries

2. Date of Death Month / Day / Year: October 17 2001

3. Time of Death: 150 AM

4a. Facility Name *(If not institution, give street and number)*: Heartland Health Care Center - Adelphi

4b. City, Town, or Location of Death: Adelphi

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 214-36-1881

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 4, 1939

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3023 Gumwood Drive

10f. Zip Code: 20783

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Legal Secretary

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Matthew A. Farrell

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Mae Cahill

19a. Informant's Name/Relationship *(Type, Print)*: John Holland- Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3023 Gumwood Drive Hyattsville MD 20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery

Date: 10-20-01

20c. Location - City or Town, State: Brentwood MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ft. Lincoln Funeral Home 3401 Bladensburg Rd Brentwood Maryland 20722

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma LUNG with Brain Metastases — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: perforated Sigmoid diverticulum

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D01852

29d. Date signed *(Month, Day, Year)*: October 17 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A. DEVORE MD 4303 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 18 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35042

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Arthur Mandville Farrell
2. Dete of Death (Month, Day, Year): October 9, 2001
3. Time of Death: 9:50 a.m.
4e. Facility Neme *(If not institution, give street and number)*: 5703 Legation Court
4b. City, Town, or Location of Death: New Carrollton
4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 577-52-7049
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)*: 63 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Oct. 13, 1937
9. Birthplece *(Stete or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5703 Legation Court
10f. Zip Code: 20784
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: VIETNAM
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Comptroller
16b. Kind of Business/Industry: Hotels
17. Fether's Neme *(First, Middle, Last)*: George Joseph Farrell
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Margaret Ethel Steele
19e. Informent's Neme/Reletionship *(Type, Print)*: Michael P. Farrell - Brother
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 5703 Legation Court, New Carrollton, MD 20784
20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Cedar Hill Cemetery
Date: 10/12/01
20c. Location - City or Town, Stete: Suitland, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in deeth):
e. Cardiovascular Arrest
Due to (or as e consequence of):
b. Cardiovascular Disease
Due to (or es a consequence of):
c. Congestive Heart Failure
Due to (or es e consequence of):
d.

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

26a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ploce of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es steted. 2☐ **Medicel Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, date end ploce, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature]
29c. License number: MD 31408
29d. Date signed *(Month, Dey, Yeer)*: October 16, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Sharon Baratz, M.D., 2150 Pennsylvania Ave., #3201, Washington, DC 20037

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 19 2001
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(12)

John Foster
CJ
01-5974-033

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 113001:ITEMS#23a,ptII,27per ME G80I ss

Certificate of Death

Reg. No. 2001 35043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Day	Yaar	3. Tima of Death
John W. Foster, Jr.	October	22	2001	07:05 A.M

4a. Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Daath	4c. County of Death
Southern Maryland Hospital Center	Clinton	Prince George's

Funeral Director

5. Social Security Number	8. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
250-52-1708	1☒M 2☐F	64 Yrs.					1/3/37	Greenville,S.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
D.C.	N/A	Washington	1☒Yas 2☐No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
1305 Upshur St.,N.W.	20011	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yas 2☒No If Yes, Give Yaar or Datas:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highast grade completed)		16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th		Truck Driver	Transportation

17. Fether's Name (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maidan Surname)
John W. Foster, Sr.	Willie Mae Boyd

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)
Sherman D. Foster/Son	1446 Savannah St.,S.E.,Wash.,D.C. 20032

20a. Method of Disposition	20b. Placa of Disposition (Nama of cemetary, crematory or othar place)	Data	20c. Location - City or Town, Stata
1☐Burial 2☒Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	Chesapeake Crematory,Inc.	10/29/01	Beltsville,Md.

21. Signature of Funeral Service Licensee	22. Name and Addrass of Facility
▶ Barry W Graef	H.S.Washington & Sons Co.,Inc. 4927 Burroughs Ave.,N.E.,Wash.,D.C. 20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar the moda of dying, such es cardiac or raspiratory arrast, shock, or heart failura. List only ona ceusa on aach lina.

Approximata Intarval Batwaen Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d. Dua to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yas, outcoma of pregnancy	23d. Data of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnent at time of daath 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

CHRONIC NARCOTISM

23a. Did tobacco usa contributa to tha causa of death? 1☐Yas 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to completion of cause of death?
1☒Yas 2☐No	1☒Yas 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
☒Yes 2☐No	Hospitel: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Othar: 4☐Nursing Home 5☐Rasidance 8☐Other (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Yaar)	28b. Time of Injury M	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined			1☐Yas 2☐No	
	28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)			28f. Location (Straet and Numbar or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as statad. 2☒ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar statad.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signad (Month, Day, Yaar)
▶ Stephen S. Radentz, M.D	O.C.M.E.	October 23, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Stephen S. Radentz, M.D 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signatura
OCT 29 2001	Brenda G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Alva Feemster
CJ
01-5955-033

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 110901:ITEMS#23a,27 per ME 030901 ss

Certificate of Death

Reg. No. 2001 35044

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Alva	Feemster		October	21	2001	07:45 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7658 South Arbory Court	Laurel	Prince George's

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-74-9481	1☐M 2☒F	45 Yrs.					May 7, 1956	Washington,DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Laurel	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7658 South Arbory Lane	20707	U.S.

11. Maritat Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2yrs.	Automation Clerk	U.S. Coast Guard

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Alphonzo Feemster	Rosa B. Floyd

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rosa B. Holley(Mother)	2414 Mary Place Ft.Washington,MD 20744

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Resurrection Cemetery	Oct.26,2001	Clinton,MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Austin Royster Funeral Home, 3821 14th St, N.W. Washington,DC 20011

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	October 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary G. Apple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 25 2001	Barbara G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35045

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SARA JANE FEEHLEY
2. Date of Death: Month 10 Day 22 Year 2001
3. Time of Death: 4:20 AM
4a. Facility Name *(If not institution, give street and number)*: 1500 Teal Dr.
4b. City, Town, or Location of Death: Ocean City
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 213-60-7622
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7/17/1917
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Ocean City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1500 Teal Dr.
10f. Zip Code: 21842
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse
16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: Samuel B. Bowser
18. Mother's Name *(First, Middle, Maiden Surname)*: Irene Schueler

19a. Informant's Name/Relationship *(Type, Print)*: George Feehley/ Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1500 Teal Dr. Ocean City, MD 21842

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cape Henlopen Crematory
Date: 10/22/01
20c. Location - City or Town, State: Frankford, DE

21. Signature of Funeral Service Licensee: [signature] 1000284
22. Name end Address of Facility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death): e. Renal Failure — 1-2 months
Due to (or as e consequence of): Ovarian Cancer — 4 years
Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Last:
b. Due to (or es a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Plece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bill Greer, MD
29c. License number: D-35764
29d. Date signed *(Month, Day, Year)*: 10/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bill Greer, MD 124 N. Main Street Berlin, Md. 21811

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 23 2001
32. Registrer's Signeture: Jennie G. Sparks

ET 10

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funerel director, page 2 should be detached for use es the buriel-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIOLET VICTORIA FULLER

2. Date of Death: Month OCTOBER Day 16 Year 2001

3. Time of Death: 2006 PM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 213-26-4654

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): September 6, 1929

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 401 South Potomac Street

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

18b. Kind of Business/Industry: Dresss Manufacturer

17. Father's Name (First, Middle, Last): Joseph Bard Cornelius

18. Mother's Name (First, Middle, Maiden Surname): Violet Victoria Shawley

19a. Informant's Name/Relationship (Type, Print): Helen M. Harden Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1329 Marshall Street, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematorium

Date: 10-18-2001

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: ▶ R. Noel Brady

22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bronchogenic Carcinoma — Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ___ 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D21457

29d. Date signed (Month, Day, Year): 10-17-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL WAHEED, MD - 12821 - OAK HILL AVE. HAGERSTOWN. MD 21742

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001

32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Fuller, Violet Victoria

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35047

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Perkins French
2. Date of Death (Month, Day, Year): Oct. 20, 2001
3. Time of Death: 3:50 P. M.
4a. Facility Name (If not institution, give street and number): Coffman Nursing Home
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-36-3556
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 16, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9828 Sharpsburg Pike
10f. Zip Code: 21742
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): teacher
16b. Kind of Business/Industry: school

17. Father's Name (First, Middle, Last): James Kingsley Noel, Sr.
18. Mother's Name (First, Middle, Meiden Surneme): Iola Derr Perkins

19a. Informent's Name/Relationship (Type, Print): Georgiann N. Breichner Guardian
19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1117 Oak Hill Avenue Hagerstown, Maryland 21742

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Smithsburg Crematory
Date: 10/22/01
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street Hagerstown, maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finat disease or condition resulting in death): a. Stroke — Due to (or as a consequence of): — 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia; hypertension
renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ E.R./Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and ptace, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: [signature] Amved Chen, MD
29c. License number: D36655
29d. Date signed (Month, Dey, Year): Oct. 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1185 Mt. Aetna Rd. Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Dey, Year): OCT 2 2 2001
32. Registrar's Signature: [signature] D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

Name known to physician

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #'s 10e.& 19b.Per FH PGC 10-22-01 cr

Certificate of Death

Reg. No. 2001 35048

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Gaskins

2. Date of Death (Month, Day, Year): October 14 2001

3. Time of Death: 7:15 PM

4a. Facility Name (If not institution, give street and number): Heartland Health Care Center - Adelphi

4b. City, Town, or Location of Death: Adelphi

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-58-1741

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 11,1945

9. Birthplace (State or Foreign Country): Washington,DC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: ☒Yes 2☐No

10e. Street and Number: 7114 ~~714~~ E. Kilmer St.

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Warren Gaskins

18. Mother's Name (First, Middle, Maiden Surname): Helen Coates

19a. Informant's Name/Relationship (Type, Print): Katrina Gaskins/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~714~~ 7114 E. Kilmer St. Landover, MD 20785

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cem.

Date: 10/19/01

20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: K.E. Wh

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Renal failure

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jay Ocuin M.D.

29c. License number: Md. D0021955

29d. Date signed (Month, Day, Year): 10-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jay Ocuin, M.D. 106 Irving St. N.W. Suite 418 Washington, DC 20010

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #20b.c 10/23/01 PGC PCP Cert. ELM

Certificate of Death

Reg. No. 2001 35049

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur Green, Sr

2. Date of Death: Month October Day 13 Year 2001

3. Time of Death: 6 55 PM

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 578-50-0569

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 7, 1937

9. Birthplace (State or Foreign Country): Wash., DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1604 Electric Ave.

10f. Zip Code: 20785

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Crew Chief

16b. Kind of Business/Industry: WSSC - Private

17. Father's Name (First, Middle, Last): Robert Green

18. Mother's Name (First, Middle, Maiden Surname): Pearl V. Thomas

19a. Informant's Name/Relationship (Type, Print): Barbara Green - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1604 Electric Ave., Landover, MD 20785

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ~~Harmony Memorial Park~~ Mt. Olivet Cemetery

Date: 10/19/2001

20c. Location - City or Town, State: Washington, DC ~~Landover, MD~~

21. Signature of Funeral Service Licensee: John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism — 1 week

Due to (or as a consequence of):

b. Deep Venous Thrombosis — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Small Cell Lung Cancer — 1 year

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P13412

29d. Date signed (Month, Day, Year): October 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Summers MD 22 South Green Street Baltimore MD 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001

32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35050

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Coy Gill

2. Date of Death (Month, Day, Year): October 13, 2001

3. Time of Death: 8:30 A.M.

4a. Facility Name (If not institution, give street and number): St. Thomas More Nursing and Rehabilitation Center

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 244-14-7895

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 1, 1911

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 4922 LaSalle Road St. Thomas More Nursing and Rehabilitation Center

10f. Zip Code: 20782

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Allen Gill

18. Mother's Name (First, Middle, Maiden Surname): Julie Ann Wallace

19a. Informant's Name/Relationship (Type, Print): Edward Gill (Son) & Dione R. Grant-Gill(daughter-in-law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3128 Brinkley Road,Apt.202;Temple Hills,Maryland 20748

20a. Method of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland National Memorial Park

Date:

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Peggy S. Robbins

22. Name and Address of Facility: R. N. Horton Company Morticians, Inc. 600 Kennedy Street,N.W.;Washington,D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Atherosclerotic Cardiovascular Disease	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Carcinoid Tumor

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year):

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elwin G. Bustos

29c. License number: D42936

29d. Date signed (Month, Day, Year): October 18 , 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Elwin G. Bustos, M.D.;1160 Varnum Street,N.E.;Suite 213;Washington,D.C. 20017

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001

32. Registrar's Signature: George B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35051

Amend #25. Per ME PGC 10-19-01 cr

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Wayne Gossett

2. Date of Death (Month, Day, Year): October 17, 2001

3. Time of Death: 8:10 PM

4a. Facility Name (If not institution, give street and number): 4602 HartTwick Road

4b. City, Town, or Location of Death: College Park

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 254-84-5010

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year):

9. Birthplace (State or Foreign Country):

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: College Park

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4602 Hartwick Road

10f. Zip Code: 20740

10g. Citizen of What Country: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Electrical

17. Father's Name (First, Middle, Last): Luther Horace Gossett

18. Mother's Name (First, Middle, Maiden Surname): Candis Mabel Singleton

19a. Informant's Name/Relationship (Type, Print): Richard Barton Gossett- Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 678 Moreland Road., Griffin, Georgia 30224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Griffin Memorial Gardens

Date: 10-16-01

20c. Location - City or Town, State: Griffin, Georgia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Gasch's Funeral Home P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes ~~2☐ No~~

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year):

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], DO

29c. License number: H00557927

29d. Date signed (Month, Day, Year): October 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester 300 Hospital Drive Cheverly Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(12)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35052

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ISATA GIBATEH

2. Date of Death Month/Day/Year: AUGUST 25, 2001

3. Time of Death: 8:25 A.M

4a. Facility Name *(If not institution, give street and number)*: WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: none

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 4, 1935

9. Birthplace *(State or Foreign Country)*: SIERRA LEONE WA

Usual Residence of Decedent

10a. State: Md. | 10b. County: Prince Georges | 10c. City, Town or Location: Riverdale | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6355 64th Ave, # A 5 | 10f. Zip Code: 20737 | 10g. Citizen of What Country?: Sierra Leone, W.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Lansana Kamara

18. Mother's Name *(First, Middle, Maiden Surname)*: Mamusu Kamara

19a. Informant's Name/Relationship *(Type, Print)*: Lansana Gibateh/ Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6355 64th Ave. # A5, Riverdal Md. 20737

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Family Cemetery | Date: 9/11/01

20c. Location - City or Town, State: Sierra Leone, W.A.

21. Signature of Funeral Service Licensee: K. E. W

22. Name and Address of Facility: Johnson & Jenkins Funeral Home 716 Kennedy St., N.W. Wash. D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b. Methicillin Resistant Staphylococcus Aureus infection

Due to (or es a consequence of):

c. Aspiration pneumonia

Due to (or as a consequenca of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coagulopathy, Multiple Myeloma, Anemia
lower Gastrointestinal bleed, Hypokalemia
Pathological Compression fracture T12 due to Multiple Myeloma

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D51083

29d. Date signed *(Month, Day, Year)*: 08-27-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Yisa. O. Yussuf 6712 Village Park Drive, Greenbelt MD 20770

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

OCT 15 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35053

GREEN, JOHN G. DR 10-10-01 @ 1030 AM RDH. JUMANI MA# 221438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
John	Girard	Green, Sr.	October 10, 2001	10:30 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
408-09-9820	1 [X] M 2 [ ] F	81 Yrs.			Nov. 5, 1919	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Clinton	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8600 Mike Shapiro Drive # 714	20735	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII 1944-1945	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th	N/A	Site Seeing Guide	Tourism

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel M. Green	Dorothy Kraft

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Theresa M. Green (Wife)	8600 Mike Shapiro Drive #714 Clinton, MD 20735

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Maryland State Veterans Cemetery	Oct. 17, 2001	Cheltenham, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIOMYOPATHY.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE.	4 DAYS. EXPIRED ON
	Due to (or as a consequence of): c. STAPHYLOCOCCAL PNEUMONIA.	10/10/01 AT
	Due to (or as a consequence of): d.	10:30AM.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Satish Jumani M.D.	D35295	10/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SATISH JUMANI, 10 St. Patricks Drive, Suite 208, WALDORF, MD 20603.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 15 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

OCT 15 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35054

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vernice Green
2. Date of Death (Month, Day, Year): Oct. 7, 2001
3. Time of Death: 7:21 P.M.
4a. Facility Name (If not institution, give street and number): Bowie Hospital
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-42-2381
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 31, 1932
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 15000 Jeremiah Lane
10f. Zip Code: 20721
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yes, Giva Yaar or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Dept. of Defense

17. Father's Nama (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Sarah Fleet

19a. Informant's Name/Reletionship (Type, Print): Saul Green III/Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 5008 Montauk Ave. New London, Ct. 06320

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Nema of cemetery, crametory or other piece): Ft. Lincoln Cemetery
Date: 10-15-01
20c. Location - City or Town, State: Brentwood, Md.

21. Signature of Funeral Service Licensee: ▶ J. P. Marshall
22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St.N.W. Washington, D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter tha mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in deeth): a. Hypertensive Vascular Disease
Due to (or as e consequence of):
Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last: b. Hypertension
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ R A Varma MD
29c. License number: D0043211
29d. Date signed (Month, Day, Year): 10/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R A Varma MD 1221 Mercantile Lane MD 20774

State Registrar

31. Date filed (Month, Day, Year): OCT 16 2001
32. Registrar's Signatura: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

(10)

Amended
Item#8/SC/WCHD
1- For State Registrar Per FH/10-18-2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35055

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EBER MONTGOMERY GIPE
2. Date of Death: Month October Day 13 Year 2001
3. Time of Death: 02:19 A M
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 196-14-2099
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 23, ~~2001~~ 1919
9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 428 Vermont Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use (retired)): Machinist
16b. Kind of Business/Industry: Manufacture of Vending Machines

17. Father's Name (First, Middle, Last): Charles Eber Gipe
18. Mother's Name (First, Middle, Maiden Surname): Emma Jane Miller

19a. Informant's Name/Relationship (Type, Print): Ruth Arlene Gipe Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 428 Vermont Avenue, Hagerstown, Md. 21740

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Pk.
Date: 10-17-2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: ▶ R. Todd Brady
22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute myocardial infarction	24 hrs
Due to (or as a consequence of): b.	Coronary artery Disease	years
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimers Dementia
Hypertension

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown
24e. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No
28. Place of Death (Check only one): Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: D44996
29d. Date signed (Month, Day, Year): Oct 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zafar Malik MD 20311 Lappans Rd Boonsboro, MD 21713

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001
32. Registrar's Signature: ▶ Sandra G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Eber Montgomery Gipe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35056

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY LOUISE GLINOWIECKI
2. Date of Death (Month, Day, Year): October 17 2001
3. Time of Death: 0359 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 212-36-4657
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/2/1938
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Ocean City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9203 Mediterranean Dr.
10f. Zip Code: 21842
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): John Thomas Dunn, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Helen Carroll

19a. Informant's Name/Relationship (Type, Print): Walter Glinowiecki
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9203 Mediterranean Dr. Ocean City, MD 21842

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cape Henlopen Crematory
Date: 10/17/01
20c. Location - City or Town, State: Frankford, DE

21. Signature of Funeral Service Licensee: ▶ W. Eric Burbage
22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA — Approximate Interval: 3 WEEKS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. COPD
Due to (or as a consequence of):
c. LUNG CANCER — Approximate Interval: 3 MONTHS
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert Allen, M.D.
29c. License number: D29168
29d. Date signed (Month, Day, Year): 10/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT B. ALLEN, MD. 100 Power St., Salisbury, MD. 21801

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Mary Glinowiecki 212-36-4657

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CM 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35057

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Isaac Henry	October 9, 2001	5:45 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HCR Manor Care 600 Largo Rd	Largo	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-14-9389	1 X M 2 F	91 Yrs.			May 10, 1910	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Upper Marlboro	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10802 Sugar Maple Terrace	20774	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
3rd		Carpenter	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Abraham Henry	Annette Jones

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gladys Blake/Wife	10802 Sugar Maple Terrace Upper Marlboro, MD 20774

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Maryland Veterans	10-16-2001	Cheltenham, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	J.B. Jenkins Funeral Home 7474 Landover Rd LAndover, MD 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardiovascular Disease	4yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____ 9 Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D32261	10-9-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael S. Feldman 9700 Annapolis Rd, Lanham MD 20706

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

OCT 1 8 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Day	Year	3. Time of Death
Michelle Holly	10	10	2001	10:47PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
177-40-4674	1☐M 2☒F	47 Yrs.			07-14-1954	Pittsburgh, PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Bowie	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2010 Alban Lane	20716	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2yrs	Administrative Assistant	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James R. Cleveland	Hattie M. Powell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Derrill E. Holly/Husband	2010 Alban Lane Bowie, MD 20716

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Peters Cemetery	10-16-01	Pittsburgh, PA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a.	Metabolic Acidosis	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): b.	Cardiac Dysfunction	days
Due to (or as a consequence of): c.	Sepsis Syndrome	days
Due to (or as a consequence of): d.	Acute Respiratory Distress Syndrome	days

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia
Thrombocytopenia
Coagulopathy

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
K. Michael Figaro	D0052865	October 10th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. Michael Figaro, MD 3001 Hopital Dr. Cheverly, MD 20785

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

CR

(15)

OCT 15 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35059

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice E. Heinrich

2. Date of Death (Month, Day, Year): October 12, 2001

3. Time of Death: 8:05 P.M.

4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent Center

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213 10 8494

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 5, 1909

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Mt. Rainier

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3117 Varnum Street

10f. Zip Code: 20712

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerical

16b. Kind of Business/Industry: United Association Plumbers/Steamfitters

17. Father's Name *(First, Middle, Last)*: James A. Nichols

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Elizabeth Rich

19a. Informant's Name/Relationship *(Type, Print)*: Marjorie L. Willett Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4108 Cadle Creek Rd. Edgewater Maryland 21037

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery

Date: Oct. 16, 2001

20c. Location - City or Town, State: Brentwood Maryland

21. Signature of Funeral Service Licensee: Robert E. Evans

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers disease

congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D00295 71

29d. Date signed *(Month, Day, Year)*: 10/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Ropez MD 1655 Crofton Blvd. #101, Crofton MD 21114

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 2001

32. Registrar's Signature: Barbara B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

OCT 16 2001

01-5797-033
B.K.S
SHARON D. HOSKINS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35060

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Sharon Denise Hoskins	OCT. 11, 2001	1:44 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGES HOSPITAL CENTER	CHEVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplece (Stete or Foreign Country)
577-74-5388	1☐M 2☒F	45 Yrs.			9-21-1956	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Glenarden	X☐Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
7701 Glenarden Parkway	20706	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Personal Management	Private

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Herbert Hoover Coleman, Sr.	Marcellina Louise Robinson

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Verlon Hoskins/Son	7701 Glenarden Parkway Lanham, MD 20706

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Arlington Nat'l. Cem.	10/19/2001	Arlington, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K.E. Wil	J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respirary arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsel end Death
Immediate Cause (Final disease or condition resulting in death)	a. Occlusive Pulmonary Thromboembolism	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☑Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Obesity

23e. Did tobacco use contribute to the cause of death?	24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐Yes 2☑No 3☐Probebly 4☐Unknown	1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶	O.C.M.E	OCT. 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

(12)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	Sandra B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35061

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth Ann Harris
2. Date of Death Month Dey Year: October 7, 2001
3. Time of Death: 7:40 pm
4a. Facility Neme *(If not institution, give street end number)*: Genesis Elder Care
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 565-34-0248
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 94 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Aug. 25, 1907
9. Birthplace *(Stete or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. Stete: California
10b. County: Sonoma
10c. City, Town or Location: Santa Rosa
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 131 Haytona Drive
10f. Zip Code: 95403
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Public School System

17. Fether's Neme *(First, Middle, Last)*: Samuel James Matthews
18. Mother's Name *(First, Middle, Meiden Surneme)*: Minnie Katherine Powell

19a. Informent's Neme/Relationship *(Type, Print)*: Gail A. George - Daughter
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 131 Haytona Drive, Santa Rosa, CA 95403

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory
Date: 10/11/01
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Dan Mundell
22. Name end Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in death): e. Myocardial Infarction — Immediate
Due to (or es e consequence of):
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or as e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: P. Henjum MD
29c. License number: D35045
29d. Date signed *(Month, Dey, Year)*: October 11, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Philip G. Henjum, M.D., 3416 Olandwood Ct., #204, Olney, MD 20832

State Registrar

31. Date filed *(Month, Dey, Year)*: OCT 15 2001
32. Registrer's Signeture: Barbara G. Goodall

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35062

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maggie Lena Harmon
2. Date of Death: Month 10 Day 15 Year 01
3. Time of Death: 1940
4a. Facility Name (If not institution, give street and number): Waterview HC Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 220-26-1749
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 11, 1910
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: SNOW HILL
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5680-CASTLE HILL RD.
10f. Zip Code: 21863
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): UNK
College (1-4or 5+): UNK
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLEANED PLANTS
16b. Kind of Business/Industry: BUNTING NURSERY

17. Father's Name (First, Middle, Last): JOHN THOMAS WATERS
18. Mother's Name (First, Middle, Maiden Surname): MARY H. STEVENSON WATERS

19a. Informant's Name/Relationship (Type, Print): IRA T. STEVENSON - SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 E. FEDERAL ST. SNOW HILL MD. 21863

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): GEORGETOWN BPT. CH. CEM. Date: 10/20/01
20c. Location - City or Town, State: SNOW HILL, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: BENNIE SMITH F/H 917 W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart taiture. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Finet disease or condition resulting in death)
a. CVA — YRS.
Due to (or as a consequence of):
b. HTN — 11
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Dementia — 11
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: [signature] MD
29c. License number: D47099
29d. Date signed (Month, Dey, Year): 10-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. Panchi MD 106 Milford St. #504B Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended
Item#5./Per FH
WCHD/10-29-2001
SC

1- For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 35063
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEWIS SAMUEL HORST
2. Date of Death (Month, Day, Year): October 16 2001
3. Time of Death: 0411 AM
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: ~~220-20-1951~~ 220-16-1951
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 27, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 17312 W. Washington Street
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): President
16b. Kind of Business/Industry: Milk Transfer Co.

17. Father's Name (First, Middle, Last): Earl Kendle Horst
18. Mother's Name (First, Middle, Maiden Surname): Lillian Barnhart

19a. Informant's Name/Relationship (Type, Print): Frances F. Horst/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17312 W. Washington St., Hagerstown, MD 21740

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery
Date: Oct.19,2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A. Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death) a.	VENTRICULAR FIBRILATION	5H
Due to (or as a consequence of): b.	MYOCARDIAL INFARCTION	1Y
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last. Due to (or as a consequence of): c.	DIABETES MELLITIS	10Y
Due to (or as a consequence of): d.	HYPERTENSION	15Y

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Menner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated.
29b. Signature and title of certifier
29c. License number: D52323
29d. Date signed (Month, Day, Year): Oct. 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Waseem 19414-C Leitersburg Pike, Hag. Md 21742

State Registrar

31. Date filed (Month, Day, Yeer): OCT 2 2 2001
32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LEWIS SAMUEL HORST December 27, 1923

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35064

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Inez M. Jones

2. Date of Death Month Day Year: Oct. 13, 2001

3. Time of Death: 4:10p.m.

4a. Facility Name *(If not institution, give street and number)*: 5721 Grosvenor Lane (Mariners Health Care)

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579 18 4111

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Sept. 3, 1917

9. Birthplace *(State or Foreign Country)*: S.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 5721 Grosvenor Lane

10f. Zip Code: 20814

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yas 2☒No *Specify:* X

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12yrs. / College (1-4or 5+)

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Crossing Guard

16b. Kind of Business/Industry: School System

17. Father's Name *(First, Middle, Last)*: Ada Madden

18. Mother's Name *(First, Middle, Meiden Sumame)*: Kate Barksdale

19a. Informent's Name/Relationship *(Type, Print)*: Delphine G. Ross / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4113 Russell Ave. #3 Mt. Rainer MD. 20712

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Mt. Olivet Cemetery

Date: 10/19/2001

20c. Location - City or Town, State: Wash.,D.C.

21. Signature of Funeral Service Licensee: Duane Smith

22. Name and Address of Facility: John T. Rhines Co. 3030 12th St.,N.E. Wash.D.C. 20017

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joel Schulman MD

29c. License number: 020516

29d. Date signed *(Month, Dey, Year)*: October 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joel Schulman 9410 Old Georgetown Rd Bethesda MD 20814

State Registrar

31. Date filed *(Month, Dey, Year)*: OCT 18 2001

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35065

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH JOHNSON

2. Date of Death (Month, Day, Year): OCTOBER 10, 2001

3. Time of Death: 6:30 PM

4a. Facility Name (If not institution, give street and number): 5206 THE ALAMEDA

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 216-30-7609

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/2/1914

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 5206 THE ALAMEDA

10f. Zip Code: 21239

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESPERSON

18b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): MAURICE DIXON

18. Mother's Name (First, Middle, Maiden Surname): SARAH FIELDS

19a. Informant's Name/Reletionship (Type, Print): LAWRENCE JOHNSON SR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 50 HAWAII AVE,NE, WASHINGTON,DC 20011

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEM. PARK — Date: 10/17/01

20c. Location - City or Town, State: BALTIMORE,MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST.,NW,WASH.,DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death): CANCER OF PANCREAS — 4 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

a. _____ Due to (or as e consequence of):

b. _____ Due to (or as a consequence of):

c. _____ Due to (or as a consequence of):

d. _____

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier:

29c. License number: D19423

29d. Date signed (Month, Day, Year): 10/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5601 LOCK RAVEN BLVD., BALTIMORE, MD 21239

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar: Amend #23a Per PHys. 10/18/01 ELH

Reg. No. 2001 35066

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Evelyn C. Johnson		2. Date of Death: Month October Day 3 Year 2001	3. Time of Death: 1630 M
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital	4b. City, Town, or Location of Death: Clinton	4c. County of Death: Prince George's	
5. Social Security Number: 248-56-0208	6. Sex: 1☐M 2☒F	7. Age (In yrs. last birthday): 69 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 9, 1932	9. Birthplace (State or Foreign Country): South Carolina		

Usual Residence of Decedent

10a. State: Maryland	10b. County: Prince George's	10c. City, Town or Location: Temple Hills	10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 3103 Goodhope Ave., #708	10f. Zip Code: 20748	10g. Citizen of What Country?: United States	

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:	14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary	16b. Kind of Business/Industry: Government	
17. Father's Name (First, Middle, Last): Martin Mixon	18. Mother's Name (First, Middle, Maiden Surname): Carrie Johnson		
19a. Informant's Name/Relationship (Type, Print): Stephanie Johnson/Daughter	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 - 54th St., S.E. Wash., DC 20019		

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery	Date: 10/9/2001	20c. Location - City or Town, State: Brentwood, MD
21. Signature of Funeral Service Licensee: John L. Stewart, III	22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019		

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Chronic Renal Failure Cardio Pulmonary arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Sepsis	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple CVAs. Stage IV Pressure Ulcers HTN Ulcers, Hypertension, Chronic Renal Failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number: D0004637 4	29d. Date signed (Month, Day, Year): 10/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anthony Thomas 11701 Livingston Rd #207 Ft Washington MD 20744

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001	32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0058.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Johnson, Evelyn 10-03-01 Expired 1630 ne. A. Thomas

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Thomas Jones, III

2. Data of Death Month: October Day: 13 Year: 2001

3. Time of Death: 0820

4a. Facility Name (If not institution, give street and number): 11010 Mount Lubentia Way

4b. City, Town, or Location of Death: Largo

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 197 32 7567

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): June 3, 1942

9. Birthplace (State or Foreign Country): Philadelphia, PA

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11010 Mount Lubentia Way

10f. Zip Coda: 20774

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No — If Yas, Giva Year or Datas: 1961 1966

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Raca - Amarican Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 Collega (1-4or 5+): 3

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Maintenance Tech Supervisor

16b. Kind of Businass/Industry: U.S. Postal Service

17. Fathar's Nama (First, Middla, Last): Rufus Jones

18. Mother's Nama (First, Middla, Maidan Sumama): Bessie Mae Colter

19a. Informant's Name/Reletionship (Type, Print): Phyllis O. Jones (Wife)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 11010 Mt. Lubentia Way, Upper Marlboro, MD 20774

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cametary, cramatory or othar placa): Lee Crematory Oct 15, 2001

Data:

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Mark D. Park

22. Nama and Addrass of Facility: Lee Funeral Home, Inc 6633 Old Old Alexandria Ferry Rd, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on aach line.

Approximata Intarval Batwaen Onset and Death

Immediata Cause (Finai disaasa or condition resulting in death): a. Arteriosclerotic Hypertensive Heart Disease

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Ceuse (Disease or Injury that initiated events resulting in daath) Last:

b.

Dua to (or as a consequanca of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☐ No

24b. Were autopsy findings availabla prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case rafarrad to medical examiner? 1☑ Yas 2☐ No

26. Place of Daath (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☑ Rasidanca 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to tha causa(s) and mannar as stated. 2☑ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester, MD

29c. Licensa number: H005592?

29d. Data signed (Month, Day, Year): October 14, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Data filed (Month, Day, Year): OCT 15 2001

32. Registrar's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

OCT 15 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35068

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM ARCHIE JACKSON

2. Date of Death: Month 10 Day 20 Year 2001

3. Time of Death: 21:20

4a. Facility Name (If not institution, give street and number): 8263 Bowlend Road

4b. City, Town, or Location of Death: Pocomoke City

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 218-14-2562

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7/27/1921

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Somerset

10c. City, Town or Location: Pocomoke City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8263 Bowlend Road

10f. Zip Code: 21851

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Joseph Stanley Jackson

18. Mother's Name (First, Middle, Maiden Surname): Eva Olivia Mariner

19a. Informant's Name/Relationship (Type, Print): Mary Elizabeth Jackson (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8263 Bowlend Rd., Pocomoke City, MD 21851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): First Baptist Cemetery

Date: 10/24/2001

20c. Location - City or Town, State: Pocomoke City, MD

21. Signature of Funeral Service Licensee: Michael A. Dean MO1129

22. Name and Address of Facility: Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MESOTHELIOMA — 18 MONTHS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. G. Santiano MD

29c. Licensa number: D02556

29d. Date signed (Month, Day, Year): 10/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.G. Santiano, MD 100 8th St. Pocomoke, MD 21851

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ed 3+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #18. Per FH PGC 10-17-01 cr

Certificate of Death

Reg. No. 2001 35069

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lettie King

2. Date of Death: Month Oct. Day 09 Year 2001

3. Time of Death: 2:00 PM

4a. Facility Name (If not institution, give street and number): ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: Tacoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 410-32-3323

6. Sex: 1☐M 2☐F

7. Age (In yrs, last birthday): 84 Yrs.

If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Aug. 7, 1917

9. Birthplace (State or Foreign Country): Portland, Ak

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Silver Springs

10d. Inside City Limits: X☐Yes 2☐No

10e. Street and Number: 9800 Hadin Street

10f. Zip Code: 20903

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Wife

16b. Kind of Business/Industry: Doomestic

17. Father's Name (First, Middle, Last): Jonnie Grays

18. Mother's Name (First, Middle, Maiden Surname): ~~Lucilla Goodwin~~ Lucilla Goodwin

19a. Informant's Name/Relationship (Type, Print): William Troy King/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9800 Hadin Street Silver Springs, Maryland 20903

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Elmwood Cemetery

Date: 10/13/01

20c. Location - City or Town, State: Memphis Tenn.

21. Signature of Funeral Service Licensee: ▶ Roger L Mason

22. Name and Address of Facility: Sterling Funeral Service 1601 Kenilworth Avenue Northeast Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finat disease or condition resulting in death)

a. ACute Respiratory Failure — Approximate Interval Between Onset and Death: 5 days

Due to (or as a consequence of):

b. Chronic Obstructive Lung Disease — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Alfor Munyo MD

29c. License number: D12582

29d. Date signed (Month, Day, Year): October 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7600 Carroll Avenue Takoma Park, MD 20912

State Registrar

31. Date filed (Month, Day, Year): OCT 17 2001

32. Registrar's Signature: Barbara B. Goode

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(1)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35070

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Sara Frances Kroll	Oct 15, 2001	22:55 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212 10 2306	1☐M 2☒F X	85 Yrs.			Nov 13, 1915	Johnstown, PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Temple Hills	1☐Yes 2☒No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7300 Temple Hills Road	20748	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married XX Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates: XX	1☐Yes 2☒No XX Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Housewife	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Andrew Davis	Bertha Flowers

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Polly Greene (DAUGHTER)	6370 Vale Court, Alexandria Virginia 22312

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Washington National Cemetery	Oct 19, 2001	Suitland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Louis L. Hart	Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Maryland 20735

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mark R. Dumais M.D.	D0053813	10/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr Dumais, M.D. 7501 Surrats Road, Clinton, Maryland 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 2001	Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Kroll, Sara expired @ 2255 10-15-01 Dr. Dumais

(4)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35071

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Chandrika Sunandan Kulkarni

2. Date of Death — Month: October Day: 14 Year: 2001

3. Time of Death: 0050

4a. Facility Name (If not institution, give street and number): Prince George's Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 242-43-6419

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 20, 1936

9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 607 Evening Star Place

10f. Zip Code: 20721

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian Indian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Physician

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Motibhai Maganbhai Patel

18. Mother's Name (First, Middle, Maiden Surname): Hiraben Motighai Hiraben

19a. Informant's Name/Relationship (Type, Print): Sunandan Bhalchandra Kulkarni/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 607 Evening Star Place Mitchellville, MD 20721

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Geo. Wash. University Medical Center

Date: October 15 2001

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvestre, DO

29c. License number: H00539?7

29d. Date signed (Month, Day, Year): October 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvestre, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): OCT 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35072

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VERNON H. KING
2. Data of Death (Month, Day, Year): October 17, 2001
3. Time of Death: 0450 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 229-78-7410
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 4 1952
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Virginia
10b. County: Accomack
10c. City, Town or Location: Hallwood
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12306 Melissa Lane
10f. Zip Code: 23359
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 74/76
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Parts Salesman
16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Thornton Hunter King
18. Mother's Name (First, Middle, Maiden Surname): Shirley M. Ferris

19a. Informant's Name/Relationship (Type, Print): Judith T. Shaw/Fiance
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12306 Melissa Lane-Hallwood VA 23359

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Island Cremetorium
Data: 10-18-01
20c. Location - City or Town, State: Chincoteague VA

21. Signature of Funeral Service Licensee: James N. Fox
22. Name and Address of Facility: Fox Funeral Home, P O Box 278-Temperanceville VA 23442

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Esophageal Varices Hemorrhage — Approximate Interval Between Onset and Death: <2Y
Due to (or as a consequence of):
b. Cirrhosis — 5Yo
Due to (or as a consequence of):
c. Hepatitis - C — 15 Yo
Due to (or as a consequence of):
d. Alcohol Abuse

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fatal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Acute Renal Failure
Hyperkalemia

23a. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert Brandon M.D.
29c. License number: D0058743
29d. Data signed (Month, Day, Year): 10/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Brandon M.D. 1201 Pemberton Dr. Salisbury MD 21801

State Registrar

31. Data filed (Month, Day, Year): OCT 19 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

VERNON KING 229-78-7410 WICOMICO 23A

ET 15+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ROGER D. LYNG	October 15 2001	0220 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
482-22-5058	1☒M 2☐F	75 Yrs.			Dec. 12, 1925	Minnesota

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Prince Georges	Bowie	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12312 Stonehaven Lane	20715	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	7	Personnel management	US Gov't.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Phillip A. Lyng	Lucille Stensrud

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donna T. Lyng Wife	12312 Stonehaven Lane, Bowie, Md. 20715

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crem.	10-19-01	Alexandria, VA.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ISCHEMIC CARDIOMYOPATHY	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. RENAL FAILURE	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] Hutchinson MD	D50016	October, 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BARBARA HUTCHINSON 64 FRANKLIN STREET ANNAPOLIS

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(15)

OCT 1 7 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No. 2001 35074

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michaelle Laventure

2. Date of Death Month Day Year: October 15, 2001

3. Time of Death: 12:18 PM

4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 081-48-8429

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 22, 1918

9. Birthplace *(State or Foreign Country)*: Haiti

Usual Residence of Decedent

10a. State: Florida

10b. County: Miami-Dade

10c. City, Town or Location: Miami

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 16600 SW 101th Avenue

10f. Zip Code: 33157

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Francique Adelson

18. Mother's Name *(First, Middle, Maiden Surname)*: Altide Girauld

19a. Informant's Name/Relationship *(Type, Print)*: Eric Laventure - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16600 SW 101th Ave., Miami, Florida 33157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Park South

Date: 10-20-2001

20c. Location - City or Town, State: Miami, Florida

21. Signature of Funeral Service Licensee: Shawn E Wells

22. Name and Address of Facility: Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic Cardiomyopathy

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Diabetes Mellitus

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0055132

29d. Date signed *(Month, Day, Year)*: October 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Palmer, M.D. 1328 Southern Avenue, SE suite 310 Washington,D.C. 20032

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 18 2001

32. Registrar's Signature: Sandra G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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LAVENTURE, MICHELLE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35075

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerald Kay Livingston
2. Date of Death (Month, Day, Year): October 18, 2001
3. Time of Death: 8:50 a.m.
4a. Facility Name (If not institution, give street and number): 6311 45th Place
4b. City, Town, or Location of Death: Riverdale
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 226-18-6950
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 19, 1919
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6311 45th Place
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Married 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Equipment Installer
16b. Kind of Business/Industry: Western Electric

17. Father's Name (First, Middle, Last): Herbert Livingston
18. Mother's Name (First, Middle, Maiden Surneme): Carrie Bailey

19a. Intormant's Name/Relationship (Type, Print): Dawn M. Worsham - Daughter
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 6311 45th Place, Riverdale, MD 20737

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Cedar Hill Cemetery
Dete: 10/22/01
20c. Location - City or Town, Stete: Suitland, Maryland

21. Signature of Funeral Service Licensee: Dorothy Jean Wirty
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville MD 20781

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset and Death
Immediate Cause (Finel disease or condition resulting in deeth)	a. Respiratory Failure	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	b. Circulatory Failure	
	Due to (or as a consequence of):	
	c. Coronary Artery Disease	
	Due to (or as a consequence of):	
	d. Myocardial Disease	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, term, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner as stated. 2 [ ] Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: Anthony Bruno M.D. 42552.
29c. License number
29d. Date signed (Month, Dey, Year): October 18, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Anthony Bruno, M.D., 8824 Cunningham Drive, Ste. E, Greenbelt, MD 20770

State Registrar

31. Dete tiled (Month, Day, Year): OCT 19 2001
32. Registrer's Signeture: Sandra B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

OCT 15 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 35076

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rachel Elizabeth Mariner Coffin Lewers

2. Date of Death Month: SEPT Day: 7 Year: 2001

3. Time of Death: 1350

4a. Facility Name *(If not Institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-30-8331

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 12, 1914

9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6332 Mary Jane Drive

10f. Zip Code: 21801

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: William Mariner

18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Rickards Mariner

19a. Informant's Name/Relationship *(Type, Print)*: Robert Coffin, Sr. Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 477 Princess Anne, MD 21853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Springhill Memory Gardens

Date: 9-11-01

20c. Location - City or Town, State: Hebron, Maryland

21. Signature of Funeral Service Licensee: H.C. Jewell Jr.

22. Name and Address of Facility: Short Funeral Home 13 E. Grove Street Delmar, DE 19940

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. PNEUMONIA	1 WK.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DM.

DEMENTIA

ASCVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mahesh Moondra

29c. License number: D32014

29d. Date signed *(Month, Day, Year)*: 9/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAHESH MOONDRA MD 106 MILFORD ST-SUITE SALISBURY MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 11 2001

32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Rachel Lewers 214-30-8331

6DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 35077

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Joseph LONG
2. Date of Death: Month October Day 18 Year 2001
3. Time of Death: 2:15 p.m.
4a. Facility Name (If not institution, give street and number): 619 Highland Way
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 726-09-9748
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 19, 1930
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 619 Highland Way
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1948-52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): line supervisor/inspector
16b. Kind of Business/Industry: truck mfg.

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Curtis Long - son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 619 Highland Way, Hagerstown, Md. 21740

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory
Date: 10-19-01
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that causad the daath. Do not enter the mode of dying, such es cardiac or raspiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	Lung Cancer	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Tobacco abuse	years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D0054451
29d. Date signed (Month, Day, Year): October 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brian Bonham 3019 Vertrie Court Myersville MD

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35078

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Debra	Ann	McLean	October 13, 2001	11:27PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☒F	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplece (State or Foreign Country)
237-13-2358		47 Yrs.			April 30,1954	North Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1☐Yes 2☒No
Maryland	Prince George's	Upper Marlboro	

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
209 King James Road	20774	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, Whlte, etc.
1☒Never Married 2☐ Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
N/A	N/A	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
Alexander McLean	Mary Jones

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Betty Johnson (Sister)	209 King James Road Upper Marlboro, Maryland 20774

20a. Method of Disposition 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	20b. Placa of Disposition (Neme of cemetery, crematory or other pleca)	Date	20c. Location - City or Town, Stete
	Lee Crematory	Oct. 16, 2001	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stacy E. Sitt	Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Pneummia.	2weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated avents resulting in death) Last	b. Due to (or as e consequence of): Downs Syndrome	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Dther significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Maaner of Death 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ William J Tanner MD	D35206	OCTOBER 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William T. TANNER MD 11701 Livingston Rd, Ft. Wash. MD

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signeture
OCT 17 2001	Barbara B. Sparks

DHMH 17 Rev 1/2001

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Christine	Elsie	Medlin	October 14, 2001	11:40AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince George's

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☒F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
077 36 7376		56			Dec. 18, 1944	Germany

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Beltsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4427 Romlon Street #203	20705	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	N/A	Secretary	Building

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Johann Hermann	Solomia Babanko

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Natasha Medlin (Daughter)	26602 Mattie Ct. Mechanicsville MD 20659

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lee Crematory	Oct 16, 2001	Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma lung

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ P.S. Aujla Attending	D 42580	October 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P.S. Aujla M.D. 5632 Annapolis Road #13 Bladensburg, Maryland 20710

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(3)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35080

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Blanche	B.	McCormick	October 14, 2001	8:41PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George's

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☐F	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
251-07-8538	XX	88 Yrs.			July 31, 1913	South Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Morningside	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4107 Maple Road	20746	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	N/A	Cafeteria Manager	Prince George's County Schools(BOE)

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Lewis Bozard	Ada Viola Davis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Richard M. McCormick, Jr. (Son)	9604 Glen View Drive Clinton, Maryland 20735

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Memorial Park Cemetery	10-20-2001	Orangeburg, S.C.

21. Signature of Funeral Service Licensee: Donna L. Beard

22. Name and Address of Facility: Lee Funeral Home, Inc. 20735 6633 Old Alexandria Ferry Road Clinton, MD

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIOMYOPATHY	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. HYPERTENSION	30 years
	Due to (or as a consequence of): c. AORTIC STENOSIS	10 years
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CROHN'S DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	MD 52741	10/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLINE CAINE 11701 Livingston Rd Ft Washington MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 2001	Donna L. Beard

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

McCormick, Blanch expired @ 8:41P 10/14/01

(10)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #23a Prt. II Per Phys. PGC 10-17-01 cr

Certificate of Death

2001 35081
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ruth L. Murgia	October 16, 2001	9:38A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctors Community Hospital	Lanham	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-26-8586	1☐M 2☒F	75 Yrs.			Nov. 4, 1925	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Prince Georges	Upper Marlboro	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12801 Keverton Drive	20774	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry R. McVay	Emma C. Quinn

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pam McCue daughter	1772 Cattail Meadows Drive, Woodbine, Md. 21797

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Crestlawn Cemetery 10-19-01	Sykesville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Beall	Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Severe degree of dehydration.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Severe gastroenterites.	
	Due to (or as a consequence of): c. Severe electrolyte imbalance	
	Due to (or as a consequence of): d. Severe Coronary artery Disease.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Atrial fibrillation with rapid rate
~~Gastrointestinal bleeding with aspiration~~

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D085720	10/16/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
TOMAS J. HERNANDEZ, MD 7505 GREENWAY CENTER SUITE T-6 GREENBELT, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 2001	Barbara B. Sanders

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

R. Murgia T.O.D 9:38 A.M.

(6)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35082

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD MORGAN

2. Date of Death (Month, Day, Year): October 16, 2001

3. Time of Death: 0139 AM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 577-88-4679

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-24-58

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4908 Alson Drive, #202

10f. Zip Code: 21229

10g. Citizen of What Country? U.S.A.

11. Maritat Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Health Care Assistant

18b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): John Morgan

18. Mother's Name (First, Middle, Maiden Surname): Audrey Williams

19a. Informant's Name/Relationship (Type, Print): Audrey Morgan - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 19th Street, S.E. Washington, D.C. 20003

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Riverdale Park Crematory

Date: 10-18-2001

20c. Location - City or Town, State: Riverdale, Maryland

21. Signature of Funeral Service Licensee: Wanda C. Bacon

22. Name and Address of Facility: Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, DC 20010

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepatoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Human Immunodeficiency Virus

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicat examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Kenneth Applegate MD

29c. License number: D38543

29d. Date signed (Month, Day, Year): October 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin H. Schneider MD 900 Caton Avenue Baltimore, Maryland 21229

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001

32. Registrar's Signature: Sandra G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME MORGAN, DONALD
Division of Vital Records, P.O. Box 68760,

SR

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Munson
2. Date of Death (Month, Day, Year): October 14, 2001
3. Time of Death: 3:25 A M
4a. Facility Name (If not institution, give street and number): Heartland Hospice
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 234-34-4545
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 20,1921
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Mitchellville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 10403 Fairlakes Terrace
10f. Zip Code: 20721
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Sam Munson
18. Mother's Name (First, Middle, Maiden Surname): Lizzie Brillou

19a. Informant's Name/Relationship (Type, Print): Don Lawson Early, Jr. /Grandson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10403 Fairlakes Terrace Mitchellville,MD 20721

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Riverdale Crematory
Date: 10/18/2001
20c. Location - City or Town, State: Riverdale, MD

21. Signature of Funeral Service Licensee: L. E. W...
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Adenocarcinoma — 1 Month

Due to (or as a consequence of):
b. Gastric Adenocarcinoma — 3 Years

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Wes decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal Insufficiency
Anemia, Hypertension

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: R. Ashby MD
29c. License number: D31326
29d. Date signed (Month, Day, Year): October 18, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Ashby 12164 Central Ave. Suite 223 Bowie, MD 20721

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

CR

(6)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35084

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Henry Manuel	10 / 16 / 01	3:20 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-60-5872	1☒ M 2☐ F	48 Yrs.			11-7-1952	Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Upper Marlboro	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6315 South Osborne Rd	20772	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Engineer	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Taskico Manuel	Ollie Mae Bailey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Wilson-Manuel/Wife	6315 South Osborne Rd Upper Marlboro, MD 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Resurrection Cemetery	10-22-2001	Clinton, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. E. W	J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brain death — Approximate Interval Between Onset and Death:

Due to (or as a consequence of):

b. Massive cerebral infarction — 36 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Subarachnoid hemorrhage — ≈ 42 hrs

Due to (or as a consequence of):

d. Ruptured intracranial aneurysm — ≈ 42 hrs

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

None

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Sharon R. Marselas, MD	D22026	10/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sharon R. Marselas, MD 12070 Old Line Centre Suite 205 Waldorf, MD 20602

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	Sandra B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Manuel, Henry expired 10-16-01 @ 1520 dr. marselas

CR

20

OCT 1 9 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35085

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Earl Edward Miller

2. Data of Death Month Day Year: October 17, 2001

3. Time of Death: 12:16 pm

4a. Facility Name *(If not institution, give street and number)*: 4603 Knox Road

4b. City, Town, or Location of Death: College Park

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 212-20-1762

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Aug. 2, 1914

9. Birthplace *(State or Foreign Country)*: Kansas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: College Park

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4603 Knox Road

10f. Zip Code: 20740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Economist

16b. Kind of Business/Industry: U.S. Dept. of Agriculture

17. Father's Name *(First, Middle, Last)*: Charles Edward Miller

18. Mother's Name *(First, Middle, Maiden Surname)*: Flossie Pearl Follin

19a. Informant's Name/Relationship *(Type, Print)*: Mary Lewis Miller - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4603 Knox Road, College Park, MD 20740

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 10/18/01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service licensee: Dorothy Jean Wirtz

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure — 6 Weeks

Due to (or as a consequence of): b. Coronary Artery Disease — 5 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Phillip W. Poth, MD

29c. License number: D22309

29d. Date signed *(Month, Day, Year)*: October 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Phillip W. Poth, M.D., 9013 Flower Avenue, Silver Spring, MD 20901

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001

32. Registrar's Signature: Jennifer D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

(10)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend # 8. Per FH PGC 10-18-01 cr **Certificate of Death** Reg. No. 2001 35086

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANDREW MOTT
2. Date of Death: Month: October Day: 11 Year: 2001
3. Time of Death: 8:45 AM
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE City

Funeral Director

5. Social Security Number: 217 13 5554
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 24 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Nov. ~~11~~ 9, 1976
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Crownsville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1406 Lowerview Court
10f. Zip Code: 21032
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Church Deacon
16b. Kind of Business/Industry: Theology

17. Father's Name (First, Middle, Last): Richard Mott
18. Mother's Name (First, Middle, Maiden Surname): Deborah Murray

19a. Informant's Name/Relationship (Type, Print): Patricia Driver Aunt
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2402 Keene Place Bowie Maryland 20715

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Memorial Gardens
Date: Oct. 15, 2001
20c. Location - City or Town, State: Davidsonville MD

21. Signature of Funeral Service Licensee: ▶ Michael L. Bryan
22. Name and Address of Facility: Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie Maryland 20715

CR

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death) a.	Chronic Mydoytic Leukemia (CML)	1 year
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Sepsis	9 days
Due to (or as a consequence of):		
c.	Respiratory failure	7 days
Due to (or as a consequence of):		
d.	Renal failure	5 days.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner statad.

29b. Signature and title of certifier: ▶ Mobashery MEDICAL RESIDENT
29c. Licanse number: P13396
29d. Date signed (Month, Day, Year): october 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NILOU MOBASHERY DEPARTMENT OF INTERNAL MEDICINE. UNIVERSITY OF MARYLAND.

State Registrar

31. Date filed (Month, Day, Year): OCT 15 2001
32. Registrar's Signature: Debra G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35087

Physician /Medical Examiner

1. Decadant's Name *(First, Middle, Last)*: Eleanor Louise Mazzucco
2. Data of Death Month / Day / Yaar: 10 / 11 / 01
3. Tima of Death: 5:30 PM
4a. Facility Name *(If not institution, giva straat and number)*: Villa Rosa Nursing Home
4b. City, Town, or Location of Death: Mitchelville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-05-1312
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 02/14/1910
9. Birthplaca *(Stata or Foraign Country)*: Washington, D.C.

Usual Rasidance of Decedent

10a. Stata: Maryland
10b. County: Prince George's
10c. City, Town or Location: Camp Springs
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 5712 Camp Springs Avenue
10f. Zip Coda: 20748
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Clerk
16b. Kind of Businass/Industry: Labor Unions

17. Fathar's Nama *(First, Middle, Last)*: Joseph Oliveto
18. Mothar's Name *(First, Middle, Maiden Surname)*: Maria Caccavo

19a. Informant's Name/Ralationship *(Type, Print)*: Anthony P. Mazzucco / Son
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 5712 Camp Springs Avenue Camp Springs, MD. 20748

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of camatary, cramatory or othar placa)*: Mt. Olivet Cemetery
Data: 10/15/2001
20c. Location - City or Town, Stata: Washington, D.C.

21. Signatura of Funaral Service Licensaa: George P. Kalas Jr.
22. Nama and Addrass of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Road, Oxon Hill, Maryland 20745

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that ceused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or Haart failura. List only one causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final diseese or condition rasulting in daath):
e. Failure to thrive — months
Dua to (or as a consequance of):
b. Dysphagia Dementia — yrs
Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Ceusa (Disaasa or injury that initiated avants rasulting in death) Lest
Dua to (or as a consequence of):
c.
Due to (or as e consaquence of):
d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying causa givan in Part I.: Aspiration pneumia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was casa referrad to medical axaminar? 1☐ Yas 2☒ No
26. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidanca 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurrad at the tima, data and placa, and dua to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurrad at the tima, date and placa, and dua to tha cause(s) and mannar stated.
29b. Signatura and title of certifier:
29c. Licansa number: D12261
29d. Data signad *(Month, Day, Yaar)*: 10-12-01
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): 9500 Annapolis Rd A-4, Lanham MD 20706 Richard Feldman M.D.

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 15 2001
32. Registrar's Signatura: B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35088

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Samuel McConnell

2. Date of Death: Month: October Dey: 10 Year: 2001

3. Time of Death: 2335

4e. Facility Name (If not institution, give street and number): 5900 Pontiac Street

4b. City, Town, or Location of Death: Berwyn Heights

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 220-50-9180

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Dec. 16, 1946

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Berwyn Heights

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 5900 Pontiac Street

10f. Zip Code: 20740

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: VIETNAM

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elamantary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor

16b. Kind of Businass/Industry: Self Employed

17. Fether's Neme (First, Middle, Last): James A. McConnell, Sr.

18. Mothar's Nama (First, Middle, Maiden Surnama): Jean E. Ailes

19a. Informant's Neme/Relationship (Type, Print): Michael L. McConnell - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 5900 Pontiac Street, Berwyn Heights, MD 20740

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Fort Lincoln Cemetery

Date: 10/16/01

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Dan Mansell

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or haert tailura. List only ona causa on aach lina.

Approximete Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in daath)

a. Arteriosclerotic Cardiovascular Heart Disease

Due to (or as e consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disaase or Injury that initiated events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Pert I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Wara eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes casa referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, daath occurred at tha time, data end piece, end dua to tha cause(s) end mannar as stated. 2☒ **Medical Examiner:** On the basis of examination end/or invastigation, in my opinion, death occurred et the time, data and place, and due to the ceuse(s) and manner stetad.

29b. Signature and title of certifier: Salvador Sylvester DO

29c. License number: H0055927

29d. Date signed (Month, Day, Year): October 13, 2001

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester 3001 Hospital Drive Cheverly, Maryland 20785

State Registrar

31. Dete filed (Month, Day, Year): OCT 15 2001

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 35089

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED JANE MIDDLEKAUFF

2. Date of Death: Month Oct Day 16 Year 2001

3. Time of Death: 1:00 P.M.

4a. Facility Name (If not institution, give street and number): Fahrney-Keedy Nursing Home

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 216-14-5345

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last Birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 22, 1911

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 330 West Side Ave.

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounting

16b. Kind of Business/Industry: Law Office

17. Father's Name (First, Middle, Last): Irvin R. Middlekauff

18. Mother's Name (First, Middle, Maiden Surname): Stella K. Bostetter

19a. Informant's Name/Relationship (Type, Print): David K. Poole Jr. P/R

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12917 Cathedral Ave. Hagerstown, Md. 21742

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory

Date: Oct. 17, 2001

20c. Location - City or Town, State: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis

22. Name and Address of Facility: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Anorexia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0050362

29d. Date signed (Month, Day, Year): 10/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 22911 Jefferson Blvd Smithsburg MD 21783

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001

32. Registrar's Signature: G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Mildred Jane Middlekauff

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35090

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Newman
2. Date of Death (Month, Day, Year): October 8, 2001
3. Time of Death: 7:45 a.m.
4a. Facility Name *(If not institution, give street and number)*: Manor Care Nursing Home
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 202-10-2634
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: July 17, 1918
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2501 Musgrove Road
10f. Zip Code: 20904
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Patient Coordinator
16b. Kind of Business/Industry: Private Industry

17. Father's Name *(First, Middle, Last)*: Peter Crawley
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Yanochko

19a. Informant's Name/Relationship *(Type, Print)*: Patricia A. Newman - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6816 Front Royal Rd., Springfield, VA 33262

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cemetery
Data: 10/15/01
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Henry L. Fox
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Arrest
Due to (or as a consequence of):
b. Dementia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M. Mahl
29c. License number: D25430
29d. Data signed *(Month, Day, Year)*: October 16, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 13982 Baltimore Ave Laurel, MD 20707

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 17 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH NAPPI
2. Date of Death (Month, Day, Year): 10 - 11 - 01
3. Time of Death: 11:15 pm

4a. Facility Name (If not institution, give street and number): Pineview Nursing Home
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-84-7941
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/12/1908
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3211 28th Parkway
10f. Zip Code: 20748
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In Home

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Joseph Nappi / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3211 28th Parkway Temple Hills, Maryland 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery — Date: 10/16/2001
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Jose P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D-18545
29d. Data signed (Month, Day, Year): OCTOBER 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip Wisotsky 12070 Old Line Ctr. #207 Waldorf, MD 20602

State Registrar

31. Date filed (Month, Day, Year): OCT 15 2001
32. Registrar's Signature: Eugene B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

OCT 1 2 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Claire Nixon
2. Date of Death (Month, Day, Year): October 12, 2001
3. Time of Death: 1:47 P M
4a. Facility Name (If not institution, give street and number): Prince Georges Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-26-4689
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 15, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Hanover Hills
10d. Inside City Limits: ☒1 Yes 2☐No
10e. Street and Number: 6722 Darby Road
10f. Zip Code: 20784
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Weigher & Wrapper
18b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): William A. Lloyd
18. Mother's Name (First, Middle, Maiden Surname): Mary B. Deutch

19a. Informant's Name/Relationship (Type, Print): John Fladurg- Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6722 Darby Road Hanover Hills MD 20784

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Funeral
Date: 10-17-2001
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Thom E Wells.
22. Name and Address of Facility: Ft. Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dying — hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Aspiration Pneumia — DAY
Due to (or as a consequence of):
c. Uremic bowel — DAY
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D32261
29d. Date signed (Month, Day, Year): 10-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] Fladurg MD 6722 Darby Rd Hanover MD

State Registrar

31. Date filed (Month, Day, Year): OCT 16 2001
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 35093

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen P. Osterhoudt

2. Date of Death Month Day Year: October 14, 2001

3. Time of Death: 7:30 a.m.

4a Facility Name *(If not Institution, give street and number)*: Sycamore Hill

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 108-14-1922

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 11, 1912

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 854 Rudder Way

10f. Zip Code: 21401

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: County School System

17. Father's Neme *(First, Middle, Last)*: Paul Peller

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Azaltovic

19e. Informent's Name/Relationship *(Type, Print)*: Patrick H. O'Brien - Son-In-Law

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3 Greenway Place Greenbelt, MD 20770

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Sleepy Hollow Cemetery | Dete: 10-20-01

20c. Location - City or Town, Stete: Westchester, New York

21. Signature of Funeral Service Licensee: Dan Mundell

22. Name end Address of Fecility: Gasch's Funeral Home P.A.

4739 Baltimore Avenue., Hyattsville, MD 20781

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): e. Congestive Heart Failure — 1 Year

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Coronary Artery Disease

23b. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Assisted Living

27. Manner of Death: 1☒ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, snd due to the cause(s) and menner steted.

29b. Signeture and title of certifier: [signature]

29c. License number: D45660

29d. Dete signed *(Month, Day, Year)*: 10-15-01

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): 14300, GALLANT fox DR 124, Bowie MD 20715

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 17 2001

32. Registrer's Signeture: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35094

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Timothy Alonzo Pittman	10 / 10 / 01	8:26 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince Georges Hospital	Cheverly	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-04-1419	1 X M 2 F	33 Yrs.			03-28-1968	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Capital Heights	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
420 Larchmont Ave.	20743	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Dispatcher	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Forris McKinley Pittman	Barbara Ann Jones

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Ann Pittman/Mother	420 Larchmond Ave, Capital Heights, MD 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Riverdale Crematory	10-16-2001	Riverdale, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
K. E. L.	J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

3

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Hypoventilatory Syndrome — years
Due to (or as a consequence of):
c. Obstructive Sleep Apnea Syndrome — years
Due to (or as a consequence of):
d. Morbid Obesity — years

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 Yes 2 X No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
K. Michael Figaro	D0052865	October 10th 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
K. Michael Figaro, MD. 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	

DHMH 17 Rev 1/2001

ORIGINAL

OCT 1 9 2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Julia C. Parks	Oct. 13, 2001	3:25a. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☐F	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578 40 9622	X	71 Yrs.			Aug. 12, 1930	Wash.,D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.		Washington, D.C.	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
1240 Kearney Street, N.E.	20017	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12yrs	5 yrs.	Professor	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Walter Pyles	Aslea Franklin

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Laurence Parks / Son	1240 Kearney St.,N.E. Wash.,D.C. 20017

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☒Buriel 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Cedar Hill Cemetery	10/19/2001	Suitland MD.

21. Signature of Funerel Service Licensee: Juan Smith

22. Name and Address of Facility: John T. Rhines Co. 3030 12th St.,N.E. Wash.,D.C. 20017

Physician /Medical Examiner

23a. Pert. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Respiratory Failure
Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

b. Metastatic Cancer
Due to (or es e consequence of):

c. Pneumonia
Due to (or as e consequence of):

d. Bowel obstruction

IF FEMALE: 23b. Wes decedent pregnant in the pest 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24e. Was an autopsy performed? 1☐Yes 2☑No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical exeminer? 1☐Yes 2☑No

28. Place of Deeth (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Yeer)	28b. Time of Injury M	28c. Injury et Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated.
2☐**Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
	D 35826	10/15/2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)
Horacio G Schiapino MD 7600 Carroll Ave Takoma Park, MD. WAH

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
OCT 18 2001	Sandra G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

10

OCT 1 8 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35096

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alfred Penny

2. Date of Death Month Day Year: 10-17-01

3. Time of Death: 5:00AM

4a. Facility Name *(If not institution, give street and number)*: Heartland Health Care Center

4b. City, Town, or Location of Death: Hyatsville

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 243-52-9236

6. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 8-12-38

9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: Md

10b. County: Prince George

10c. City, Town or Location: Forrestville

10d. Inside City Limits: XX1☐Yes 2☐No

10e. Street and Number: 3712 Apothecary Street

10f. Zip Code: 20747

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married XX2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates: XX

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Department of Public Works

16b. Kind of Business/Industry: DC Government

17. Father's Name *(First, Middle, Last)*: Charles Penny

18. Mother's Name *(First, Middle, Maiden Surname)*: Louise E. Jennifer

19a. Informant's Name/Relationship *(Type, Print)*: Lenora R Whitby

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3712 Apothecary St Forrestville Md 20747

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State XX4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harmony Memorial Park

Date: 10/23/01

20c. Location - City or Town, State: Landover, Md. 20785

21. Signature of Funeral Service Licensee: B F Taylor

22. Name and Address of Facility: BF Taylor Funeral Services Inc 1722 North Capitol Street NW

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. ____ Due to (or es e consequence of):

c. ____ Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes XX2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes XX2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Devore

29c. License number: D01852

29d. Date signed *(Month, Day, Year)*: October 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Devore 4203 Queensbury Road Hyatsville Maryland 20781

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

(2)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No 2001 35097

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tayloria Elizabeth Praither
2. Date of Death (Month, Day, Year): October 10, 2001
3. Time of Death: 11:42 PM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 220-66-7916
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 10, 1955
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8837 Rusland Court
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: U.S. Postal Service

17. Father's Name (First, Middle, Last): Clarence Praither
18. Mother's Name (First, Middle, Maiden Surname): Rachel Elizabeth Warren

19a. Informant's Name/Relationship (Type, Print): Bernice W. Dortch/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6654 Foxfire Dr., Indianapolis, IN 46214

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: 10/20/01
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ Gary P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Pulmonary Embolism	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Multiple Sclerosis
Bronchial Asthma

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D0055120
29d. Date signed (Month, Day, Year): Oct 11 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Palmer 1328 Southern Avenue Suite 310 Washington DC 20032

State Registrar

31. Data filed (Month, Day, Year): OCT 15 2001
32. Registrar's Signature: Barbara L. Rhodes

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

10-10-01 @ 2342

Praither, Tayloria expired

20

OCT 12 5081

CPM
01-6077-045
DAVID PAULL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 110601:ITEMS#23a,27,28a-f per ME C801 ss

Reg. No. 2001 35098

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
DAVID	WILLIAM	PAULL	OCTOBER 26, 2001	9:45 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2312 ALLEN DRIVE	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
259-02-3066	1☒ M 2☐ F	44 Yrs.			June 14,1957	Missouri

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Willards	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7809 Green Lewis Road	21874	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	–	Service Technician	Heating & Air

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jack Morley Paull	Marvel Lee Barnum

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rosemary Paull/Spouse	7809 Green Lewis Rd., Willards, MD 21874

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Salisbury Crematory	10/28/01	Salisbury, MD

21. Signature of Funeral Service Licensee ▶ David A. Thompson M01051

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. FREON (Chlorodifluoromethane) AND COCAINE INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ ~~Pending~~ investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. M. Tiu	O.C.M.E.	OCTOBER 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M TIU, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 30 2001	▶ Rosina B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35099

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Orlando Polk

2. Date of Death — Month: October Day: 13 Year: 2001

3. Time of Death: 0740

4a. Facility Name (If not institution, give street and number): Peninsula Regional Medical Center

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 220-12-0543

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 10, 1910

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Eden

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4117 Allen Road

10f. Zip Code: 21822

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stationary Engineer

16b. Kind of Business/Industry: College

17. Father's Name (First, Middle, Last): John Purnell Polk

18. Mother's Name (First, Middle, Maiden Surname): Naomi King

19a. Informant's Name/Relationship (Type, Print): Mabel E. Polk/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4117 Allen Road, Eden, MD 21822

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Friendship UMC Cemetery

Date: 10/19/01

20c. Location - City or Town, State: Allen, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — One Day

Due to (or as a consequence of):

b. COPD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of injury (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D39813

29d. Data signed (Month, Day, Year): 10/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Atkins, 1104 Healthway Drive, Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10 DQ

DHMH 16 Rev 6/95

Amended Item #11 Per Wife G822 8/4/03 AMH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35100

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Lawrence Peck

2. Date of Death: Month October Day 18 Year 2001

3. Time of Death: 12:32 PM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 055-44-6255

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 51 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 23, 1950

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: NY

10b. County: Queens

10c. City, Town or Location: Ozone Park

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 109-06 97th St.

10f. Zip Code: 11417

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed [ ] ~~Divorced~~

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled

16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Jamessz Peck

18. Mother's Name (First, Middle, Maiden Surname): Mildred Bergen

19a. Informant's Name/Relationship (Type, Print): Mildred Kelly/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109-06 97thSt. Ozone Park, NY 11417

20a. Method of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Calverton National

Date: 10/22/01

20c. Location - City or Town, State: Calverton, NY

21. Signature of Funeral Service Licensee: Ernest C. Burner, MBE

22. Name and Address of Facility: Burner Trade Services P.A. 1037 Dual Pl. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alcohol Abuse — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hepatitis C

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D0054451

29d. Date signed (Month, Day, Year): October 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brian Barham 3019 Ventrice Court Myersville Maryland

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001

32. Registrar's Signature: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Peck, James

93A

WASH.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. no. 2001 35101

Name: Milton Losh Porterfield

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last): Milton Losh PORTERFIELD							2. Date of Death: Month October, Day 22, Year 2001		3. Time of Death: 10:15 pm
4a. Facility Name (If not institution, give street and number): Reeders Memorial Home				4b. City, Town, or Location of Death: Boonsboro			4c. County of Death: Washington		
5. Social Security Number: 214-09-1156	6. Sex: 1☒ M 2☐ F	7. Age (In yrs. last birthday): 89 Yrs.	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year): July 24 1912		9. Birthplace (State or Foreign Country): Maryland
Usual Residence of Decedent									
10a. State: Maryland	10b. County: Washington	10c. City, Town or Location: Hagerstown							10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17925 Sand Wedge Drive			10f. Zip Code: 21740				10g. Citizen of What Country?: U.S.A.		
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4or 5+): 0	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management					16b. Kind of Business/Industry: Road Construction		
17. Father's Name (First, Middle, Last): J. Harlan Porterfield				18. Mother's Name (First, Middle, Maiden Surname): Mary E. Losh					
19a. Informant's Name/Relationship (Type, Print): Janet K. Porterfield - Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17925 Sand Wedge Drive Hagerstown, Md. 21740							
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery		Date: 10/25/01			20c. Location - City or Town, State: Hagerstown, Maryland		
21. Signature of Funeral Service Licensee: Robert B. Rankin		22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740							

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complications that caused tha daath. Do not anter tha mode of dying, such as cardiec or raspiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. probable cerebro-vascular accident	10 minutes
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Dua to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: [signature]

29c. License number: D32518

29d. Data signed (Month, Day, Year): 10/23/01

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/ 301-432-2222

State Registrar

31. Dete filed (Month, Dey, Year): OCT 2 4 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35102

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Eva Rearden	October 3, 2001	12:36 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Thomas More Nursing	Hyattsville	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-24-9294	1☐M 2☒F	88 Yrs.			March 25, 1913	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DC		Washington DC	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
4803 B. Street SE	20019	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Detes:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Nursing	Private

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Wade Gaston	Cornelia Talbert

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
William Rearden Jr - Son	4803 B. Street SE Washington DC 20019

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Ft. Lincoln Cemetery	10-09-2001	Brentwood, MD

21. Signeture of Funeral Service Licensee ▶ [signature]

22. Name end Address of Facility Ft. Lincoln Funeral Home
3401 Bladensburg Road Brentwood MD 20722

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or es a consequence of):

Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnency 1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnency 4☐Pregnant et time of death 5☐Other (specify) _____ 9☐Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D46529	October 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Victor Onyejiaka 7325A Hanover Parkway Greenbelt Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35103

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edwyn Bertram Reisman

2. Date of Death: Month October Day 12, Year 2001

3. Time of Death: 2:00P.M.

4a. Facility Name (If not institution, give street and number): 9309 Harvey Road

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-10-9895

6. Sex: 1[X] M 2[ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): December 17, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1[ ] Yes 2[X] No

10e. Street and Number: 9309 Harvey Road

10f. Zip Code: 20910

10g. Citizen of What Country?: United States

11. Marital Status: 1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1[X] Yes 2[ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1[ ] Yes 2[X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manufacturing Representative Furniture

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): Benjamin Reisman

18. Mother's Name (First, Middle, Maiden Surname): Ida Landy

19a. Informant's Name/Relationship (Type, Print): Barbara J. Reisman - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 69 Essex Avenue Montclair, New Jersey 07042

20a. Method of Disposition: 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Judean Memorial Gardens

Date: 10/14/01

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: Donald V Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction

Due to (or as a consequence of): Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure; Aortic Valve Disease

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed? 1[ ] Yes 2[X] No

24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[ ] No

25. Was case referred to medical examiner? 1[ ] Yes 2[X] No

26. Place of Death (Check only one): Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[X] Residence 8[ ] Other (Specify)

27. Manner of Death: 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1[ ] Yes 2[ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: FOSIA MD

29c. License number: D40365

29d. Date signed (Month, Day, Year): October 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter J. Sabia, M.D. 10313 Georgia Avenue, #305 Silver Spring, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year): OCT 16 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

CR

20

OCT 18 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35104

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harold Rozen
2. Date of Death (Month, Day, Year): October 14, 2001
3. Time of Death: 5:30P.

4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 028-05-7665
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug.1,1910
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6111 Montrose Road, #725
10f. Zip Code: 20852
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 1-4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Market owner
16b. Kind of Business/Industry: retail business

17. Father's Name (First, Middle, Last): Abraham Rozen
18. Mother's Name (First, Middle, Maiden Surname): Fannie Zuckerzuss

19a. Informant's Name/Relationship (Type, Print): Shirley Fried - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4970 Sentinel Drive, #302 Bethesda, Maryland 20816

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Tifereth Israel of Revere — Date: 10/17/01
20c. Location - City or Town, State: Everett, Massachusetts

21. Signature of Funeral Service Licensee: Wayne M. Harden
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia
Due to (or as a consequence of): b. Renal Failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Squamous cell Cancer of Neck; Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gary B. Wilks M.D.
29c. License number: D55258
29d. Date signed (Month, Day, Year): October 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY B. WILKS, M.D. 6121 Montrose Road Rockville Maryland 20852

State Registrar

31. Date filed (Month, Day, Year): OCT 16 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-5732-033
B.K.S
WILLIAM RIDLEY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35105

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
WILLIAM	RIDLEY	OCT. 8, 2001	2326 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGES HOSPITAL CENTER	CHEVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-56-8832	1☒M 2☐F	57 Yrs.			July 10,1944	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
District of Columbia		Washington	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4953 G Street #4B SE	20019	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Yeer or Detes:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Printer/Truck Driver	Frank Gordon Printing Company

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Walter Brown	Lydia Holt

19e. Informent's Neme/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
William K. Ridley Jr/Son	2903 W.133rd St Gardena, California 90249

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Harmony Memorial	10/20/01	Landover MD

21. Signature of Funeral Service Licensee: ▶ Wilbur R. Brugg

22. Name and Address of Facility: Robert G. Mason Funeral Home
1661 Good Hope Rd SE, Wash DC 20020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death)	a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Piece of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Piece of Injury - At home, term, street, tectory, office building, etc. (Specify)			28t. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) end manner as stated.
2☒ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Marguerite DeMarle MD	O.C.M.E	OCT. 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY ANNE A. KOMOR 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificete has been signed by the attending physician end completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

3

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 2001	Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jeffrey Rozetka	October 13, 2001	3:06 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
343-44-5367	1☐M 2☐F X	52 Yrs.			October 13, 1949	Illinois

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	New Carrollton	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5800 Mentana St.	20784	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Unemployed	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry J. Rozetka	Evelyn Reese

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Connie Roti/ Sister	6253 West 63rd St. Chicago, IL 60638

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Riverdale Crematory	10/16/01	Riverdale, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. E. Wil	J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARCINOMA LUNG	~ 6 month
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. VENTILATORY FAILURE	~3 wks
	Due to (or as a consequence of):	
	c. SEPSIS	~ 3 wks
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☒Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M. Sinayer	D-17874	10-14-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. M. NAYAR, MD 3717-38 ANG COTTAGE CITY, MARYLAND 20722

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 18 2001	Sandra G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35107

REED, MABEL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MABEL EVELYN REED

2. Date of Death Month Day Year: OCTOBER 16, 2001

3. Time of Death: 9:50 P.M.

4a. Facility Name *(If not institution, give street and number)*: BERLIN NURSING & REHABILITATION CENTER

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WOCESTER

Funeral Director

5. Social Security Number: 218-20-2275

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 29, 1909

9. Birthplace *(State or Foreign Country)*: ENGLAND

Usual Residence of Decedent

10a. State: DELAWARE

10b. County: SUSSEX

10c. City, Town or Location: SELBYVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12 SHADY PARK

10f. Zip Code: 19975

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: FRANCIS W. SMITH

18. Mother's Name *(First, Middle, Maiden Surname)*: MARIA E. SHIVERS

19a. Informant's Name/Relationship *(Type, Print)*: NANCY E. TRIGGS/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12 SHADY PARK, SELBYVILLE, DELAWARE 19975

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CREMATORY OF DELMARVA

Date: 10/17/01

20c. Location - City or Town, State: DELMAR, DELAWARE

21. Signature of Funeral Service Licensee: Charles W Hastings Jr

22. Name and Address of Facility: HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease — 5 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infarction. Coronary Artery Disease. Essential Hypertension. Renal Insufficiency. End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregorio M. Belloso M.D.

29c. License number: D 29505

29d. Date signed *(Month, Day, Year)*: 10-17-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg No. 2001 35108

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bessie Marks Rhinehart

2. Date of Death Month Day Year: October 22, 2001

3. Time of Death: 8:20 P.M.

4a. Facility Name *(If not institution, give street and number)*: Charles County Nursing Home

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 228-22-4714

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 25, 1907

9. Birthplace *(State or Foreign Country)*: Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Charles

10c. City, Town or Location: La Plata

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 10200 La Plata Road

10f. Zip Code: 20646

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: George H. Marks

18. Mother's Name *(First, Middle, Maiden Surname)*: Bettie Powell Marks

19a. Informant's Name/Reletionship *(Type, Print)*: Robert E. Tankersley / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16111 Archies Place Hughesville, MD 20637

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Gate of Heaven — Date: 10/26/01

20c. Location - City or Town, Stete: Silver Spring, Md.

21. Signature of Funeral Service Licensee: David C. Echols M00945

22. Name and Address of Facility: Arehart-Echols Funeral Home, P.A. P.O. Box 567 LaPlata, Md 20646

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. Congestive Heart Failur

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last

b. Coronary Artery Disease

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24e. Was en eutopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Deeth *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☑Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier: Michael Leatherwood

29c. License number: D21031

29d. Date signed *(Month, Dey, Year)*: 10/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Leatherwood, MD 12070 Old Line Centre, Waldorf, MD. 20601

State Registrar

31. Date filed *(Month, Dey, Year)*: OCT 24 2001

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item #8, 10/19/2001, WCHD, E.T

Certificate of Death

Reg. No. 2001 35109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irene S. ROBINSON

2. Date of Death: Month 10 Day 9 Year 01

3. Time of Death: 10:00 a.m.

4a. Facility Name (If not institution, give street and number): 500 Maple Street Apt. 6

4b. City, Town, or Location of Death: SNOW HILL

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 202-03-5484

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04/11/~~20~~ 1920

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 500 Maple Street

10f. Zip Code: 21863

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeping

16b. Kind of Business/Industry: Worcester Schools

17. Father's Name (First, Middle, Last): James Dickerson

18. Mother's Name (First, Middle, Maiden Surname): Annie Smith

19a. Informant's Name/Relationship (Type, Print): Juanita Miller (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 632 Diamond Street Phila Pa. 19122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Peace Cemetary

Date: 10/20/01

20c. Location - City or Town, State: Phila. Pa.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bennie Smith Funeral Home P.O. Box 321 Pocomoke City, md.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary arrest — 1-2 minutes

Due to (or as a consequence of):

b. Hypertension. — YEARS (>10).

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kimberly A. Richardson MD

29c. License number: D57978

29d. Date signed (Month, Day, Year): 10/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kimberly Richardson, MD 428 W. Market St Snow Hill, MD 21863

ET 6

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35110

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): PEARL P SMITH

2. Dete of Deeth Month/Day/Yeer: OCT 14 2001

3. Time of Death: 5:45 PM

4e. Fecility Name (If not institution, give street end number): RANDOLPH HILLS NURSING HOME

4b. City, Town, or Location of Death: WHEATON

4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 143-10-9449

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): DEC 11 1918

9. Birthplece (State or Foreign Country): NEW YORK

Usuel Residence of Decedent

10e. Stete: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 11807 SELFRIDGE RD

10f. Zip Code: 20906

10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: CAUCASIAN

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): SALES PERSON

16b. Kind of Business/Industry: RETAIL

17. Fether's Neme (First, Middle, Last): SAMUEL PRESSER

18. Mother's Name (First, Middle, Maiden Surname): SOPHIE LENCHUS

19e. Informent's Neme/Reletionship (Type, Print): INA F. BARKE - DAUGHTER

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 11807 SELFRIDGE ROAD SILVER SPRING, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS

Dete: 10/17/01

20c. Location - City or Town, Stete: OLNEY , MD

21. Signeture of Funerel Servica Licensee: [signature]

22. Neme and Address of Fecility: PEARSON FUNERAL HOME 472 N. WASHINGTON ST FALLS CHURCH VA 22046

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. ALZHEIMERS DEMENTIA — 4 YEARS

Due to (or es e consequenca of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest:

b.

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end manner steted.

29b. Signeture end title of certifier: [signature] Martin C. Sharget M.D.

29c. License number: D08944

29d. Dete signed (Month, Day, Yeer): 10/17/01

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MARTIN C. SHARGEL, M.D. 3720 FARRAGUT AVE KENSINGTON, MD - 20895-2110

State Registrar

31. Dete filed (Month, Day, Yeer): OCT 17 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Department of Health end Mentel Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35111

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David Anthony Smith
2. Date of Death (Month, Day, Year): October 13, 2001
3. Time of Death: 8:56 am
4a. Facility Name *(If not institution, give street and number)*: Prince Georges Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-56-4734
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 57 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 17 1944
9. Birthplace *(State or Foreign Country)*: Washington, DC

4 1/3

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4412 Dery Rd.
10f. Zip Code: 20772
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Landscaper
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Raymond Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Worthington

19a. Informant's Name/Relationship *(Type, Print)*: Gloria G. Smith/ wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4412 Dery Rd. Upper Marlboro , MD 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harmony Memorial — Date: 10/18/01
20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: ▶ Keith A. Pope MD/DR
22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD 20747

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of): HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D35947
29d. Date signed *(Month, Day, Year)*: 10/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NORMAN G. NELSON MD. 10274 CRAIG WORTH #202 Mitchellville, MD. 20721

(4)

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 2001
32. Registrar's Signature: Gordon B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Russell Grapes Stutzman

2. Date of Death (Month, Day, Year): October 14, 2001

3. Time of Death: 9:14 A.M

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 233-34-2928

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 24, 1924

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Brentwood

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3711 Allison Street

10f. Zip Code: 20722

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Staff Sergeant

16b. Kind of Business/Industry: United States Army

17. Father's Name (First, Middle, Last): Cyrus F. Stutzman

18. Mother's Name (First, Middle, Maiden Surname): Suda Alta Grapes

19a. Informant's Name/Relationship (Type, Print): Joan L. Stutzman - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3711 Allison Street., Brentwood, MD 20722

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National

Date: 10-25-01

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Dustyn Lee Wirt

22. Name and Address of Facility: Gasch's Funeral Home P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. ATRIAL FIBRILLATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HYPERTENSION

Due to (or as a consequence of):

c. CEREBRAL VASCULAR ACCIDENT.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Don Coleman

29c. License number: 57614

29d. Date signed (Month, Day, Year): 10/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Don M. Coleman MD 7600 Carroll Ave. Takoma Park, Maryland 20912

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001

32. Registrar's Signature: Barbara B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(9)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35113

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Amelia R. Sardo
2. Date of Death Month Day Year: OCT. 12 2001
3. Time of Death: 1:38P.M.
4a. Facility Name *(If not institution, give street and number)*: CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 578-24-8696
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 20, 1924
9. Birthplace *(State or Foreign Country)*: Wash. DC

Usual Residence of Decedent

10a. State: Md.
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 218 Compton Road
10f. Zip Code: 20602
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own home

17. Father's Name *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Wesley daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 218 Compton Road, Waldorf, Md. 20602

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gardens
Date: 10/16/2001
20c. Location - City or Town, State: Waldorf, MD

21. Signeture of Funeral Service Licensee: Beall
22. Name and Address of Facility: Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

To Be Completed by Funeral Director

Amelia SARDO

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krishan K Mathur
29c. License number: D-0028352
29d. Date signed *(Month, Day, Year)*: 10-11-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KRISHAN . MATHUR MD 3500 OLD WASHINGTON ROAD WALDORF MARYLAND 20602

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(11)

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 15 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 35114

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert J. Stock
2. Date of Death (Month, Day, Year): October 14, 2001
3. Time of Death: 7:30 AM
4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 579-16-7603
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 1, 1922
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3117 Belair Drive
10f. Zip Code: 20715
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sheetmetal Mechanic
16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: John Stock
18. Mother's Name *(First, Middle, Maiden Surname)*: Tina Morgan

19a. Informant's Name/Relationship *(Type, Print)*: Blanche E. Stock/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3117 Belair Drive Bowie, MD 20715

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cemetery
Date: 10/17/2001
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Beall Funeral Home 6512 NW Crain Hwy Bowie, MD 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Pancreatic Carcinoma	Months
Due to (or as a consequence of):	b. Hepatic Encephalopathy	Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Rakesh Arora MD
29c. License number: D20108
29d. Date signed *(Month, Day, Year)*: 10/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rakesh Arora 14300 Gallant Fox Lane Suite 222 Bowie, MD 20715

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 15 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 35115

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kathryn S. Somers
2. Date of Death Month / Day / Year: October 12, 2001
3. Time of Death: 9:10 PM
4a. Facility Name *(If not institution, give street and number)*: Villa Rosa Nursing Home
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 133-14-6785
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 29, 1907
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Glenn Dale
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10009 Worrell Avenue
10f. Zip Code: 20869
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Faust Ostapowitz
18. Mother's Name *(First, Middle, Maiden Surname)*: Stella Miholajewska

19a. Informant's Name/Relationship *(Type, Print)*: Joyce K. Muir daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10009 Worrell Avenue, Glenn Dale 20769

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Johns Cemetery
Date: 10-17-01
20c. Location - City or Town, State: Queens, N.Y.

21. Signature of Funeral Service Licensee: ▶ Beall
22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Congestive heart failure — 1 week

Due to (or as a consequence of):
b. Arteriosclerotic heart disease — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Roger Ingham
29c. License number: D05891
29d. Date signed *(Month, Day, Year)*: Oct. 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Roger Ingham MD, 6510 Kenilworth Ave., Riverdale, Md.

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 15 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

OCT 12 500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35116

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William Leonard Soper	October 11, 2001	12:58P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-07-2891	1☒M 2☐F	83 Yrs.			Sept 7, 1918	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Laurel	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9750 Whiskey Run	20723	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Ticket Agent	Transportation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Bernard Soper	Minnie Virginia-Unobtainable

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Soper- Daughter	9750 Whiskey Run Laurel MD 20723

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	10-12-2001	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Ft. Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular Infarction	2 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D 24997	October 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Luis A. Casas 8317 Cherry Lane Laurel MD 20707

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	▶

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35117

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JOSIE	M.	STEVENS	OCTOBER	16	2001	1747 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
222-20-3363	1☐ M 2☒ F	88 Yrs.					MAR. 14, 1913	DELAWARE

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DELAWARE	SUSSEX	SELBYVILLE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
29 BETHANY ROAD RT. 2 BOX 5B	19975	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		SALES CLERK	CLOTHING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FRED PEPPER	CORA LAYTON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WILLIAM F. STEVENS/SON	P.O. BOX 121, SELBYVILLE, DELAWARE 19975

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	REDMEN'S CEMETERY	10/20/01	SELBYVILLE, DELAWARE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Charles W Hastings	HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Polymorphic ventricular tachycardia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Type II Atrioventricular block

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Wes decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined			1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0057115	10/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENIGNO DECENA, DELMARVA HEART 104 MILFORD ST, SUITE 605 SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	▶ Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Josie Stevens 222-20-3363 10/16/01 17:47

5 1/4"

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35118

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANDY B. STAMPER, SR.
2. Date of Death (Month, Day, Year): October 17, 2001
3. Time of Death: 5:25P M
4a. Facility Name (If not institution, give street and number): 17306 Cindy Lane
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 283-16-1901
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 10, 1919
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 17306 Cindy Lane
10f. Zip Code: 21740
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Millwright
18b. Kind of Business/Industry: Truck Manufacturing

17. Father's Name (First, Middle, Last): Kenota Stamper
18. Mother's Name (First, Middle, Maiden Surname): Lillie Ellen Whitaker

19a. Informant's Name/Relationship (Type, Print): Gladys Edith Stamper/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17306 Cindy Lane, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Mem. Park
Date: Oct. 20
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A. Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEVERE, PROGRESSIVE DEMENTIA OF ALZHEIMER'S TYPE	3 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
SEIZURE DISORDER
PERIPHERAL NEUROPATHY

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: Pamela Fox Bradford
29c. License number: D38892
29d. Date signed (Month, Day, Year): 10/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAMELA FOX BRADFORD MD 11110 MEDICAL CAMPUS RD. SUITE 130 HAGERSTOWN, MD 21742

State Registrar

31. Date filed (Month, Day, Year): OCT 2 2 2001
32. Registrar's Signature: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Donald Richard Spielman	October	20	2001	09:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-12-0786	1☒M 2☐F	78 Yrs.					April 28, 1923	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Hagerstown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10938 Roessner Avenue	21740	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: W.W.II	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	0	salesman	retail appliances

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ezra Earl Spielman	Frances U. Trovinger

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janet C. Spielman - wife	10938 Roessner Ave., Hagerstown, Md. 21740

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rest Haven Cemetery	10/23/01	Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME
415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE — Approximate Interval: 20 Y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION
PULMONARY EMBOLI
AORTIC STENOSIS S/P AORTIC VALVE REPLACEMENT

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D43590	10/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
22911 Jefferson BLVD SMITHSBURG MD 21783

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35120

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIE STIFT
2. Date of Death (Month, Day, Year): Oct. 22, 2001
3. Time of Death: 11:03 AM
4a. Facility Name *(If not institution, give street and number)*: Homewood at Williamsport
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington Co.

Funeral Director

5. Social Security Number: 325-01-3290
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 24, 1910
9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 16505 Virginia Avenue
10f. Zip Code: 21795
10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 | College (1-4or 5+): 0
16s. Decedent's Usual Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fsther's Neme *(First, Middle, Last)*: Joseph Bruno
18. Mother's Name *(First, Middle, Meiden Surname)*: Catherine Coniglio

19e. Informant's Neme/Relationship *(Type, Print)*: Robert C. Stift/Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9720 Redamar Drive, Hagerstown, Maryland 21740

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Joseph's Cemetery
Date: Oct.26
20c. Location - City or Town, State: River Grove, Illinois

21. Signeture of Funerel Service Licensee: Douglas A Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home, 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deth. Do not enter the mode of dying, such es cardiac or respiretory srrest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth)
e. BRAINSTEM HERNIATION — Hours

Due to (or es a consequence of):
b. INTRACEREBRAL BLEED — 1 WEEK

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):
c. INCREASED INTRACEREBRAL PRESSURE SECOND

Due to (or as e consequence of):
d. MARKED AGITATION — MONTHS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were sutopsy findings sveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mepner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: MEDICAL DIRECTOR
29c. License number: D17067
29d. Date signed *(Month, Dey, Yeer)*: 10/22/2001

30. Neme end sddress of person who completed cause of death (Item 23a) (Type, Print): STEPHEN E. METZNER, M.D. 747 NORTHERN AVE HAGERSTOWN, MD

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 24 2001
32. Registrer's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10-22-01 11:03A

Marie Stift

NAME: Smith, Jessie Mae

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35121

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jessie Mae SMITH

2. Deta of Deeth — Month: October; Dey: 21; Year: 2001

3. Time of Deeth: 1:28 AM

4a. Facility Neme *(If not institution, giva street and number)*: Reeders Memorial Home

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-2006

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Yeer — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Dey, Year)*: June 1 1909

9. Birthplace *(Stete or Foreign Country)*: West Virginia

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Streel and Number: Route 3 Box 315-B

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Edeeation *(Specify only highest greda completed)*

Elementery/Secondary (0-12): 8

College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Her own home

17. Father's Neme *(First, Middla, Last)*: Hunter L. Good

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Dora S. Sirbaugh

19a. Informent's Neme/Reletionship *(Type, Print)*: Dolly Good - Daughter-In-Law

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3101 Napolean Avenue Tampa, Fl. 33611

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stale 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or othar piece)*: Rest Haven Cemetery

Date: 10/24/01

20c. Location - City or Town, Stete: Hagerstown, Maryland

21. Signeture of Funerel Service Licensee: Robert B Rankin

22. Nama and Addrass of Feciliity: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Pert1. Enter the diseesa, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heert fellure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death)

e. Dehydration — 3 weeks

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest

b. Anemia — 3 weeks

Due to (or es a consequence of):

c. Cardio vascular disease — months

Due to (or es a consequance of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Arteriosclerotic Cardiovascular Disease

Hypothyroidism Degenerative Joint Disease

23b. **Did tobecco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☐ No

26. Plece of Deeth *(Check only one)*

Hospitel: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner**: On tha basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner steted.

29b. Signetura and tilia of certifier: [illegible] MD

29c. Licensa number: D18019

29d. Date signed *(Month, Dey, Year)*: Oct 21, 2001

30. Nema end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): VASANT DATTA, MD 340 MILL ST HAGERSTOWN, MD 21740

State Registrar

31. Dele filed *(Month, Dey, Year)*: OCT 23 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35122

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
LOUELLA JANE SMITH	October 22 2001	0545 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-05-6431	1☐M 2☒F	94 Yrs.			Jan. 3, 1907	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington Co.	Hagerstown	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11 West Baltimore Street	21740	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	Housekeeping	Nursing Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lewis Elmer Bowman	Annie Catherine Houpt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Omer Eugene Smith/Son	7 Watermill Place, Palm Coast, Florida 32164

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Zion Cemetery	Oct.24,2001	San Mar, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Douglas A Fiery	Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Thrombotic Cerebral Vascular Accident — 3 weeks

Due to (or as a consequence of):

b. Atherosclerotic Cerebrovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dino J. Delaportas MD	D26523	October 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DINO J. DELAPORTAS MD 1110 Medical Campus Road HAGERSTOWN MD 21742

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 24 2001	Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Smith, Louella Jane

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35123

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AMANDA RUTH SKINNER

2. Date of Death Month Day Year: OCTOBER 16, 2001

3. Time of Death: 1:05 pm

4a. Facility Name (If not institution, give street and number): CHESAPEAKE WOODS CENTER

4b. City, Town, or Location of Death: CAMBRIDGE

4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 421-28-8503

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 1, 1908

9. Birthplace (State or Foreign Country): ALABAMA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: DORCHESTER

10c. City, Town or Location: EAST NEW MARKET

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 14 RAILROAD AVENUE

10f. Zip Code: 21631

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): CHARLES CRAWFORD BATTON

18. Mother's Name (First, Middle, Maiden Surname): NETTIE MOHR EVINGTON

19a. Informant's Name/Relationship (Type, Print): CAROLINE S. CLINE/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. BOX 88, EAST NEW MARKET, MARYLAND 21631

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CREMATORY OF DELMARVA

Date: 10/23/01

20c. Location - City or Town, State: DELMAR, DELAWARE

21. Signature of Funeral Service Licensee: Leonard D. Zeller

22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Colitis — 48hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. Fadden

29c. License number: D26388

29d. Date signed (Month, Day, Year): 10-17-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. Fadden 332 Collins Ave Hurlock, MD 21643

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35124

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Taylor
2. Date of Death (Month, Day, Year): Oct. 14, 2001
3. Time of Death: 6:00a.m.
4a. Facility Name (If not institution, give street and number): 1106 Burketon Rd.
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 246 12 4595
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 28, 1920
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1106 Burketon Rd.
10f. Zip Code: 20783
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12yrs | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Adminstration Asst.
16b. Kind of Business/Industry: Govt.

17. Father's Name (First, Middle, Last): John T. Barnes
18. Mother's Name (First, Middle, Maiden Surname): Cherry Ward

19a. Informant's Name/Relationship (Type, Print): Chester Woodard / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1106 Burketon Rd. Hyattsville Md. 20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
Date: 10/20/2001
20c. Location - City or Town, State: Brentwood, MD.

21. Signature of Funeral Service Licensee: Juan Smith
22. Name and Address of Facility: John T. Rhines Co. 3030 12th St.,N.E. Wash.,D.C. 20017

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Coronary Artery Disease	3 yrs.
Due to (or as a consequence of):	Atherosclerosis	10 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Hypertension	10 yrs.
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theresa Q. Berry M.D.
29c. License number: MD 1789 DC
29d. Date signed (Month, Day, Year): October 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theresa Berry, M.D. 24 Florida Ave.,N.E. Wash.,D.C.

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001
32. Registrar's Signature: Bernice B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35125

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALMA TAYLOR
2. Date of Death Month Day Year: OCTOBER 11 2001
3. Time of Death: 4:54pm
4a. Facility Name *(If not institution, give street and number)*: PRINCE GEORGE'S HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY MARYLAND
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-54-3208
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 05-10-1913
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 703 James Ridge Road
10f. Zip Code: 20721
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Spacify only highast grada complatad)*: Elementary/Secondery (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own home

17. Father's Name *(First, Middla, Last)*: Frank Lassery
18. Mother's Nama *(First, Middla, Maiden Sumama)*: Eva Cook

19a. Informant's Name/Relationship *(Type, Print)*: Almyra Williams (Daughter)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 703 James Ridge Road Bowie, Maryland 20721

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cem. Date: 10/17/01
20c. Location - City or Town, State: Bladensburg, Md. 20710

21. Signature of Funeral Service Licensee: Ralph Williams 767
22. Name and Address of Facility: Ralph Williams Funeral Service 517 - 11th St., SE; Wash., DC 20003

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad tha daath. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert failure. List only one cause on each line. — Approximate Interval Between Onsat and Death

Immediate Cause (Finel disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. ATHEROSCLEROTIC HEART DISEASE

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
HYPERTENSION
HYPERTENSIVE CARDIOMYOPATHY

23b. Did tobecco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Susan W Owens MD
29c. Licanse number: D0022751
29d. Data signad *(Month, Day, Year)*: OCTOBER 11, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN W OWENS MD PRINCE GEORGE'S HOSPITAL CENTER

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 18 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slip.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35126

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carroll Scott Tavenner
2. Date of Death (Month, Day, Year): October 6, 2001
3. Time of Death: 5:55 pm M
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-20-3027
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 14, 1922
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5006 Laguna Road
10f. Zip Code: 20740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DC Taxi Cab Driver
16b. Kind of Business/Industry: Independent

17. Father's Name (First, Middle, Last): John Tavenner
18. Mother's Name (First, Middle, Maiden Surname): Sadie (Unavailable)

19a. Informant's Name/Relationship (Type, Print): James R. Ewell - Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9707 Rhode Island Ave., College Park, MD 20740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 10/12/2001
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or comptications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic disease of the liver — Due to (or as a consequence of): — 12h

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Sr
29c. License number: D45860
29d. Date signed (Month, Day, Year): Oct 6, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 14300 GALLANT FOX LN 124, Bowie MD 20715

State Registrar

31. Date filed (Month, Day, Year): OCT 15 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

OCT 12 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George E. Trieschock
2. Date of Death (Month, Day, Year): October 20 2001
3. Time of Death: 4:06 pm
4a. Facility Name (If not institution, give street and number): Western Maryland Hospital Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 722-16-0991
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 28, 1924
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 20400 High View Court
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-1947
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technical Director
16b. Kind of Business/Industry: Appliance Manufacturer

17. Father's Name (First, Middle, Last): Theodore Trieschock
18. Mother's Name (First, Middle, Maiden Surname): Anna Cerva

19a. Informent's Name/Relationship (Type, Print): Paula Trieschock - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20400 High View Court Hagerstown, Maryland 21740

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Somerset Hills Mem. Park
Date: 10-24-01
20c. Location - City or Town, State: Basking Ridge, NJ

21. Signature of Funeral Service Licensee: Craig D. Osborne
22. Name and Address of Facility: Osborne Funeral Home, P.A. 21795, 425 S. Conococheague St. Williamsport, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of Tongue and Nopharynx — 15 yrs.
Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE — 2 MONTHS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maryann J. Shaffer
29c. License number: D28365
29d. Date signed (Month, Day, Year): 10.20.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANN J. SHAFFER 368 MILL HAGERSTOWN MD 21740 - on call. 1500 Pennsylvania Avenue Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-5700-027
crn
Oscar Amilcar Mendez Vides

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35128

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Oscar Amilcar Mendez Vides
2. Data of Death: Month: October; Dey: 07; Year: 2001
3. Time of Death: 3:16 A.M.
4a. Facility Nama *(If not institution, giva street and number)*: Interstate 95 at Route 216
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 152-08-8647
6. Sax: 1☒ M 2☐ F
7. Aga *(In yrs. last birthday)*: 23 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: March 4, 1978
9. Birthpleca *(State or Foreign Country)*: El Salvador

Usuel Residence of Decedent

10a. Stete: Virginia
10b. County: Arlington
10c. City, Town or Location: None
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1805 N. Nelson St.
10f. Zip Code: 22204
10g. Citizen of What Country?: El Salvador

11. Marital Stetus: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Wes Decedent of Hispanic Origin? (Spacify Yas or No- If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1☒ Yes 2☐ No *Specify:* El Salvador
14. Race - Amaricen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Stock Man
16b. Kind of Business/Industry: Private

17. Fathar's Nama *(First, Middle, Last)*: Manuel A. Mendez
18. Mothar's Neme *(First, Middle, Maiden Surneme)*: Paz Vides Mendez

19a. Informant's Name/Relationship *(Type, Print)*: Santos E. Idalgo - Cousin
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4 Clinton Ave. Plainfield, NJ. 07063

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cemetera Mermeja
Date: 10/20/01
20c. Location - City or Town, Stata: El San Salvador, Salvador

21. Signeture of Funeral Service Licansee:
22. Nama and Address of Facility: Arlington Funeral Home. 3901 N. Fairfax Dr. Arlington, VA. 22203

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on eech line. — Approximata Intervel Between Onset and Death

Immediate Ceusa (Final disaasa or condition resulting in death)
a. HEAD AND NECK INJURY
Due to (or as a consequence of):
b.
Due to (or as a consequance of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residanca 6☒ Other *(Specify)* at scene

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury *(Month, Dey Year)*: 10-7-01
28b. Tima of Injury: 0303 A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: DRIVER OF CAR, MPA A CAR
28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*: ROADWAY
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*: 95 N AT RT 216 HOWARD CO, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, and due to the ceuse(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end mannar statad.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed *(Month, Dey, Year)*: October 07, 2001

30. Nama end address of person who completed ceuse of death (Item 23a) (Type, Print): HAROLD A. KORELL MD. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Dey, Year)*: OCT 16 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35129

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Betty Workman	October 3, 2001	7:05 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George Hospital	Cheverly	Prince Georges

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-84-7487	1☐M 2☒F	62 Yrs.			12-29-1938	Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Landover	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2500 Markhan Lane	20785	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Nurse	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Marquise Childs	Rebecca Petty

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janice Workman/Daughter	11496 Leland Pl Waldorf, MD 20601

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Harmony Memorial	10-13-2001	Landover, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility J.B. Jenkins Funeral Home
7474 Landover Rd LAndover, MD 20785

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic Encephalopath

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c. Metastatic Lung Carcinoma

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] Catavenis, M.D.	D30318	10/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James Catavenis, MD 3001 Hospital Drive Cheverly, MD 20785

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

OCT 16 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35130

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Cotuner Wideman

2. Dete of Death (Month, Day, Year): October 7, 2001

3. Time of Death: 1747

4a. Facility Neme (If not institution, give street and number): Prince George's Hospital

4b. City, Town, or Location of Deeth: Cheverly

4c. County of Deeth: Prince George's

Funeral Director

5. Sociel Security Number: 248-40-3452

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthdey): 70 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): June 26, 1931

9. Birthplece (State or Foreign Country): McCormick, SC

Usuel Residence of Decedent

10a. Stete: DC

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1400 Whittier Pl NW #207

10f. Zip Code: 20012

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Private

17. Fether's Neme (First, Middle, Last): Fuller Banks

18. Mother's Name (First, Middle, Maiden Surneme): Rosa Bell Hayes Wideman

19a. Informent's Neme/Reletionship (Type, Print): Alma Jackson/Sister

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 603 64th Ave Capital Heights, MD 20743

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): Harmony Memorial Park

Dete: 10-15-01

20c. Location - City or Town, State: Landover, MD

21. Signeture of Funerel Service Licensee: K. E. Wi

22. Neme and Address of Fecility: J.B. Jenkins Funeral Home 7474 Landover RD Landover, MD 20785

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or raspiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximeta Intervel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in death): a. Atherosclerotic Cardiovascular Heart Disease

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b.

Due to (or as e consequance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Wara eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Descnibe how injury occurred

28a. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and pleca, end due to the cause(s) and mannar es steted. 2☒ **Medical Examiner**: On the basis of examinetion and/or invastigation, in my opinion, daath occurred et the time, date and placa, and dua to the cause(s) end menner steted.

29b. Signeture end title of certifier: Salvador Sylvester, MD

29c. License number: H0055927

29d. Date signed (Month, Day, Year): October 8, 2001

30. Nama and addrass of parson who completed cause of death (Item 23a) (Type, Print): SALVADOR SYLVESTER, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Dete filed (Month, Dey, Year): OCT 16 2001

32. Registrar's Signeture: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

OCT 16 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose C. Wahl

2. Date of Death: Month October Day 15 Year 2001

3. Time of Death: 9:30 a.m.

4a. Facility Name (If not institution, give street and number): Magnolia Gardens Nursing Home

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 058-56-5088

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): June 13, 1911

9. Birthplace (State or Foreign Country): Olean, New York

Usual Residance of Decedant

10a. Steta: Maryland

10b. County: Prince George's

10c. City, Town or Location: Riverdale

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4707 Tuckerman Street

10f. Zip Coda: 20737

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indien, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementery/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired): Homemaker

16b. Kind of Businass/Industry: Own Home

17. Father's Neme (First, Middle, Last): Joseph Dulian

18. Mother's Nama (First, Middle, Maiden Surnama): Catherine (Unknown)

19a. Informent's Name/Ralationship (Type, Print): John A. Wahl - Spouse

19b. Malling Addrass (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Code): 4707 Tuckerman Street, Riverdale, MD 20737

20a. Mathod of Disposition: 1☐ Burial 2☒ Crametion 3☐ Ramoval from Steta 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar placa): Metropolitan Crematory

Data: 10/17/01

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signeture of Funeral Service Licensee: [signature]

22. Nama and Addrass of Facility: Gasch's Funeral Home, 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximete Intarval Batween Onset and Death

Immediata Causa (Final diseasa or condition rasulting in death)

a. Aspiration Pneumonia — 3days.

Due to (or as a consequance of):

Sequentially list conditions, if sny, leading to immadiata cause. Entar Undarlying Cause (Diseasa or Injury that initiated events rasulting in death) Last

b. ____

Dua to (or as a consequence of):

c. ____

Dua to (or as a consequance of):

d. ____

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Daath (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data end place, end dua to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, date end piece, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifier: [signature]

29c. Licansa number: 047603

29d. Data signed (Month, Day, Year): 10/16/01

30. Neme and address of person who completed causa of death (Item 23a) (Type, Print): William DuBoyce, MD 4000 Mitchellville Rd B216 Bowie, MD 20716

State Registrar

31. Date filed (Month, Day, Year): OCT 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

OCT 3 2001

01-5834-033
B.K.S
MARTIN WIELERT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35132

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Martin J. Wielert	OCT. 13, 2001	2336 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGES HOSPITAL CENTER	CHEVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220 72 7653	XX 1 M 2 F	40 Yrs.			Dec. 27, 1960	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Bowie	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12108 Tulip Grove Drive	20715	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Elevator Mechanic	Elevator Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Wielert	Doris L. Wills

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William Wielert Father	1921 Northeast 59th Ct. Ft. Lauderdale FL 33308

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Huntt Crematory	Oct. 17, 2001	Waldorf Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael L. Bifle	Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie MD 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chest Injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XX No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 XX Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 XX Yes 2 No

25. Was case referred to medical examiner? XX Yes 2 No

28. Place of Death (Check only one)

Hospital: 1 Inpatient 2 XX ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death 1 Natural 2 XX Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
10-13-01	2100 M	1 Yes 2 XX No	Driver auto - auto collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State) Lanham - Severn Rd and Santa Cruz Dr.

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. XX **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E	OCT. 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 2001	Barbara B. Sparks

DHMH 17 Rev 1/2001

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

OCT 3 : 2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35133

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Phyllis Pratt Woodward
2. Date of Death Month, Day, Year: October 5, 2001
3. Time of Death: 10:50 a.m.
4a. Facility Name *(If not institution, give street and number)*: Collington Episcopal Life Care Community
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 046-09-2534
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 1, 1919
9. Birthplace *(State or Foreign Country)*: Connecticut

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Mitchellville
10d. Insida City Limits: 1☐ Yas 2☒ No
10a. Street and Number: 10450 Lottsford Road
10f. Zip Coda: 20721
10g. Citizan ot What Country?: U.S.A.

11. Marital Stetus: 1☐ Nevar Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent ot Hispanic Origin? (Specify Yas or No- It Yas, specify Cuben, Maxican, Puerto Rican, atc.): 1☐ Yes 2☐ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done dunng most of working life. DO NOT use retired)*: Bank Loan Officer
16b. Kind ot Businass/Industry: Manchester Savings Bank

17. Father's Nama *(First, Middle, Last)*: Howard Pratt
18. Mothar's Nama *(First, Middle, Meiden Sumame)*: Grace Safford

19a. Intormant's Name/Ralationship *(Type, Print)*: William Woodward - Son
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1242 D Street S.E. Washington, DC 20003

20a. Mathod ot Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Othar *(Specify)*
20b. Piece ot Disposition *(Name of cemetery, crematory or other place)*: Bethlehem United Methodist Church Cemetery
Date: 10-9-01
20c. Location - City or Town, Stata: Moneta, Virginia

21. Signeture of Funeret Service Licensee: Alfred W. Miller
22. Nama and Address of Facility: Gasch's Funeral Home P.A. 4739 Baltimore Avenue, Hyattsville MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar the *moda* of dying, such as cerdiac or raspiratory arrast, shock, or heart tailura. List only ona causa on eech lina.

Approximete Interval Between Onsat and Deeth

Immediata Causa (Final disaasa or condition resulting in death):
a. metastatic lung disease — > 1 month
Dua to (or as a consequance ot):
b. MALNUTRITION — > 3 months

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Dua to (or es e consequence of):
c. chronic obstructive lung disease — > 5 years
Dua to (or as a consequanca ot):
d. Smoking — 25 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa givan in Part I.: osteoarthritis

23b. Did tobacco use contributa to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No
24b. Wara autopsy tindings available prior to completion of ceuse ot death? 1☐ Yas 2☐ No

25. Was cesa refarred to *medical* examinar? 1☐ Yes 2☒ No
26. Placa ot Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Tima ot Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place ot Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of *my* knowledga, daath occurred at the tima, date and place, and due to the ceuse(s) and *manner* es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to tha ceuse(s) and mannar stated.

29b. Signature and title of certifier: Alain G. Champaloux MD
29c. Licensa number: D 42049
29d. Dete signed *(Month, Day, Year)*: October 5th, 2001

30. Name and address of person who completed causa ot death (Item 23a) (Type, Print): Alain G CHAMPALOUX MD. Upper Marlboro. MD. 20772

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 17 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

P WOODWARD
PHYLLIS
SR
(5)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35134

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Nellie Wheeler	October 11, 2001	9:40P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
259-07-5375	1☐ M 2☒ F	87 Yrs.			December 26, 1913	Georgia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George	Camp Springs	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6924 Allentown Rd.	20748	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Housekeeper	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry Jackson	Delia Ware

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elijah Wheeler/Spouse	6924 Allentown Rd. Camp Springs, MD. 20748

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Lincoln Memorial	10/22/2001	Suitland, MD.

21. Signature of Funeral Service Licensee: Cwyn L. Mikell

22. Name and Address of Facility: Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Urosepsis.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition; Stroke

Multi-infarct dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Paul M. Wilner MD	D41276	10/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4700 Auth Place 2nd Fl Suitland Md 20746

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 15 2001	Gordon G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dr. Wilson Paul

wheeler, Nellie expired 10-11-01 2140

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35135

WHITTINGTON, ELIZABETH
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2058

To be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELIZABETH MAE TAYLOR WHITTINGTON
2. Date of Death — Month: OCTOBER; Day: 19; Year: 2001
3. Time of Death: 5:28 A.M.
4a. Facility Name *(If not institution, give street and number)*: Berlin Nursing and Rehabilitation Center
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 215-12-6394
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 8/4/1923
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Ocean City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12525 Fleetway Dr.
10f. Zip Code: 21842
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 10; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Grocery Store

17. Father's Neme *(First, Middle, Last)*: Roland James Taylor
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Leona Mae Dunn

19a. Informent's Name/Relationship *(Type, Print)*: R. Jennings Whittington, II
19b. Melling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9835 Mason RD Berlin, MD 21811

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Evergreen Cemetery
Date: 10/23/01
20c. Location - City or Town, Stete: Berlin, MD

21. Signeture of Feneral Service Licensee: W. Fiel Burbage
22. Neme end Address of Fecility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — 5 yrs
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Essential Hypertension; Cerebrovascular arteriosclerosis with multiple CVA's. Essential Thrombocytosis

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Gregorio M. Belloso M.D.
29c. License number: D 29505
29d. Date signed *(Month, Dey, Year)*: 10-19-2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): GREGORIO M. BELLOSO, MD; 5302 CHINABERRY DR., SALISBURY, MD 21801

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

EJ 3

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 19 2001
32. Registrer's Signature: Jennie D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 35136

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Baby Boy Wright
2. Date of Death: Month October Day 19 Year 2001
3. Time of Death: 347 pm
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: N/A
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last Birthday): Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min. 2
8. Date of Birth (Month, Day, Year): 10-19-01
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 854 Harford Court
10f. Zip Code: 21202
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): UnKnown
18. Mother's Name (First, Middle, Maiden Surname): Karen Wright

19a. Informant's Name/Relationship (Type, Print): Karen Wright/mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 854 HarfordCourt-Balto. Md. 21202

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Disposal
20b. Place of Disposition (Name of cemetery, crematory or other place): Johns Hopkins Hospital
Date: 10/20/01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Deborah Evans
22. Name and Address of Facility: JHH-600 N. Wolfe St - 21287

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Extreme prematurity — 22 4/7 wks
Due to (or as a consequence of):
b. Pre-term premature rupture of membranes — mins
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Corey McGlothan MD
29c. License number: RES 000
29d. Date signed (Month, Day, Year): 10/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Corey McGlothan, MD, The Johns Hopkins Hospital 600 N Wolfe, Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): NOV 0 2 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALVIN nmi WILKES

2. Date of Death Month: OCTOBER Day: 19 Year: 2001

3. Time of Death: 6:50 P.M.

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown, MD

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 376-72-9878

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 14, 1962

9. Birthplace (State or Foreign Country): Detroit, MI

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6846 Acacia Court

10f. Zip Code: 21703

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): guard

16b. Kind of Business/Industry: prison

17. Father's Name (First, Middle, Last): Robert Wilkes

18. Mother's Name (First, Middle, Maiden Surname): Clarabell Henderson

19a. Informant's Name/Relationship (Type, Print): Ann L. Wilkes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 659 Blue Ridge Summit, PA 17214

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Hope Cemetery

Date: 10/26/01

20c. Location - City or Town, State: Livonia, MI 48150

21. Signature of Funeral Service Licensee: James A Bowersox

22. Name and Address of Facility: Grove-Bowersox Funeral Home, Inc 50 S. Broad ST. Waynesboro, PA 17268

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. subarachnoid hemorrage — 48°

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Vasospasm — 48°

Due to (or as a consequence of):

c. ruptured aneurysm — 48°

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [/] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [/] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [/] No

26. Place of Death (Check only one)

Hospital: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 [/] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M P. Qualey

29c. License number: D50813

29d. Date signed (Month, Day, Year): 10/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1150 Professional Court Suite C Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Day, Year): OCT 2 2 2001

32. Registrar's Signature: Bruce G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

WILKES, ALVIN

Per EW

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar: Amend Item 25 PER ME G801 11/05/01 RR

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 35138

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Sunday	Ogbonna	Anozie	October 24 01	7:07 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
465-02-0390	1 X M 2 ☐ F	59 Yrs.			09 27 42	Nigeria

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6410 Loch Raven Blvd	21239	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	African-American Specify:

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	5 yrs +	Professor of English	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Nathaniel A. Anozie	Margaret A. Okoroafo

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lynda Anozie-Wife	6410 Loch Raven Blvd, Baltimore, Md 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Christ's Church	11-18-01	Owerri, Nigeria

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Lola March	March F/H West 4300 Wabash Ave, Baltimore, Maryland 21215

ANOZIE, SUNDAY

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. OVERWHELMING SEPSIS	4 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): MULTI ORGAN SYSTEM FAILURE	4 days
	c. Due to (or as a consequence of): E. coli bacteremia + peritonitis	5 days
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

DISSEMINATED INTRAVASCULAR COAGULATION

STATUS POST KIDNEY TRANSPLANT

23e. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No	28. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
KEN BRADY MD	RES-000	10/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KEN BRADY 600 NORTH WOLFE STREET BALTIMORE, MD 21287-9106

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	Genevieve G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur Lee Boatwright

2. Date of Death Month Day Year: Nov. 2, 2001

3. Time of Death: 9:15 A.M

4a. Facility Name (If not institution, give street and number): 507 Campbell Lane

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 248-62-1905

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 16, 1941

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 507 Campbell Lane

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

18b. Kind of Business/Industry: Potts & Callahan

17. Father's Name (First, Middle, Last): William Boatwright

18. Mother's Name (First, Middle, Maiden Surname): Esther Mae Howard

19a. Informant's Name/Relationship (Type, Print): Charlene Boatwright/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 507 Campbell Lane Baltimore, Maryland 21212

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Pleasant Rest Cemetery

Date: 11/7/01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Jeremy Harris

22. Name and Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gastric Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Coronary Artery Disease, Seizures

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 35082

29d. Date signed (Month, Day, Year): 11/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. RAMESH 2323 ORLEANS STREET, BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Department of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35140

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Francis Donald Bokman

2. Date of Death: Month Oct. Day 27 Year 2001

3. Time of Death: 4:10 pM

4a. Facility Name *(If not institution, give street and number)*: 5534 Council Street

4b. City, Town, or Location of Death: Arbutus

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-28-7495

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sep. 7, 1933

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5534 Council Street

10f. Zip Code: 21227

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952 - 1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor

16b. Kind of Business/Industry: State Government

17. Father's Name *(First, Middle, Last)*: Clifton Jerome Bokman

18. Mother's Name *(First, Middle, Maiden Surname)*: Kate Evans

19a. Informant's Name/Relationship *(Type, Print)*: JoAnn Bokman Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5534 Council Street, Arbutus, MD 21227

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Park

Date: 11-01-2001

20c. Location - City or Town, State: Dorsey, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, MD 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death): a. Malignant Mesothelioma — 18 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant et time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probebly 4 [ ] Unknown

24e. Was en autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner es steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D24356

29d. Dete signed *(Month, Dey, Yeer)*: October 30, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Wm. C. Waterfield MD — St Agnes Cancer Center — 900 Caton Ave Balto Md 21229

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 0 5 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35141

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOCK M. BILLINGS
2. Date of Death Month Day Year: NOVEMBER 1, 2001
3. Time of Death: 12:10 A.M.
4a. Facility Name (If not institution, give street and number): 213 RACHEL CIRCLE
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 240-28-3279
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 3, 1921
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: FOREST HILL
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 213 RACHEL CIRCLE
10f. Zip Code: 21050
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 4 YRS.
College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARETAKER-MECHANIC
18b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): ELI BILLINGS
18. Mother's Name (First, Middle, Maiden Surname): LORA WHITEHEAD

19e. Informant's Name/Relationship (Type, Print): ELENA FLYNN
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050: 213 RACHEL CIRCLE FOREST HILL, MARYLAND

20e. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVANS FUNERAL CHAPEL BEL AIR, P.A.
Date: Nov. 1, 2001
20c. Location - City or Town, State: FOREST HILL MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS FUNERAL CHAPEL - BEL AIR, P.A. 21050 3 NEWPORT DRIVE FOREST HILL, MARYLAND

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerosis
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Myocardial Infarction
Due to (or as a consequence of):
c. Congestive heart failure
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
peripheral Vascular disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown
24e. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: H41069
29d. Date signed (Month, Day, Year): NOVEMBER 1, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. STANLEY M. KRAN 1308 BUSINESS CENTER WAY EDGEWOOD, MARYLAND

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 4

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35142

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CAROL BALDWIN
2. Data of Death Month: OCTOBER Day: 29 Year: 2001
3. Time of Death: 11:02AM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 234-50-6735
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): July 26, 1935
9. Birthplaca (State or Foraign Country): West Virginia

Usual Residence of Decedent

10a. Steta: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 9 Patapsco Avenue
10f. Zip Coda: 21222
10g. Citizan of What Country?: United States

11. Marital Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):
16a. Decedent's Usuat Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Housewife
16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama (First, Middla, Last): Henry Burris
18. Mother's Nama (First, Middla, Maiden Surname): Mable Harmon

19a. Informent's Neme/Ralationship (Type, Print): Brenda Dannenfelser (Daughter)
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 9 Patapsco Ave. Dundalk, Maryland 21222

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): Hilltop Service Corp. Data: 11/2/2001
20c. Location - City or Town, Stata: Towson, Maryland

21. Signeture of Funaral Service Licensee: Gregory E. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each lina.

Approximate Interval Between Onsat and Death

Immediate Causa (Final disease or condition resulting in daath)
a. HYPOXIA — 1 HOUR
Due to (or as a consequance of):
b. PNEUMONIA — 1 WEEK
Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Causa (Disease or Injury that initiated evants resulting in death) Last
Due to (or as a consequance of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.
EMPHYSEMA
ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? ☒ Yas 2☐ No
24b. Wara autopsy findings availabla prior to compilation of causa of daath? 1☐ Yas 2☒ No

25. Was casa refarred to medical examinar? 1☐ Yas 2☒ No
26. Place of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Manner of Daath: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)
28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurred at the tima, date and placa, and dua to tha cause(s) and manner stated.

29b. Signatura and title of certifier: RESIDENT PHYSICIAN
29c. Licensa number: RES-000
29d. Data signed (Month, Day, Year): OCTOBER 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type or Print): WILBUR CHEN M.D. 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

State Registrar

31. Data filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signatura:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

RR
RR 1/2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35143

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT HAROLD BROWN

2. Date of Death Month / Day / Year: October 14, 2001

3. Time of Death: 12:15 AM

4a. Facility Name *(If not institution, give street and number)*: VAMCHS Fort Howard Division

4b. City, Town, or Location of Death: Fort Howard

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214341525

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12/20/1929

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: ROSEDALE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1321 RUSTIC AVENUE

10f. Zip Code: 21237

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes: WW II

13. Was Decedent of Hispanic Origin? (Specify Yea or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MACHINIST

16b. Kind of Business/Industry: BURLINGTON FURNITURE FACTORY

17. Father's Name *(First, Middle, Last)*: LEE BROWN

18. Mother's Name *(First, Middle, Meiden Surneme)*: INA (JONES)

19a. Informant's Name/Relationship *(Type, Print)*: JANICE PORRECA (DAUGHTER)

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1321 RUSTIC AVENUE, ROSEDALE, MD 21237

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other piece)*: METRO CREMATORY

Date: 10/15/01

20c. Location - City or Town, State: CATONSVILLE, MD

21. Signeture of Funerel Service Licensee ▶ Sharon Leigh Unitas, per DVR

22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME, 1211 Chesaco Avenue ROSEDALE, MD 21237

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in death): a. SMALL CELL LUNG CANCER W/BRAIN METS

Due to (or es a consequence of):

Sequentially iist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events reeulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier ▶ Anna C. Tan, M.D.

29c. License number: D14958

29d. Date signed *(Month, Day, Year)*: October 24, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): AURORA C. TAN M.D. 9600 North Point Road Fort Howard 21052

State Registrar

31. Dete filed *(Month, Dey, Year)*: NOV 01 2001

32. Registrar's Signature ▶ Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BROWN, Robert H.

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GUS COCOLIN

2. Date of Death: Month NOV. Day 3, Year 2001

3. Time of Death: 6:00 AM

4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE - SPA CREEK

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 170-12-7131

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 18, 1918

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedant

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7914 PARK WEST DRIVE

10f. Zip Code: 21061

10g. Citizen of What Country?: UNITED STATES

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): MECHANIC

16b. Kind of Businass/Industry: TRUCKING

17. Fether's Neme (First, Middle, Last): GEORGE COCOLIN

18. Mother's Name (First, Middle, Maiden Surname): MARY JANOKAIS

19e. Informent's Name/Relationship (Type, Print): GABRIEL COCOLIN / SON

19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code): 7914 PARK WEST DR. GLEN BURNIE, MD 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEM. PARK Date: NOV. 6, 2001

20c. Location - City or Town, State: GLEN BURNIE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each lina.

Approximata Interval Batween Onset end Death

Immediate Cause (Final disease or condition resulting in daath)
a. Aspiration Pneumonia — 1 month

Due to (or as a consequance of):
b. chronic obstructive pulmonary disease

Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the undarlying ceusa givan in Part I.

23b. Did tobacco uss contributs to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only ona): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, date and place, and dua to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated.

29b. Signeture and title of certifier: [signature]

29c. License number: D47137

29d. Date signed (Month, Day, Year): November 5, 2001

30. Neme and address of person who completed cause of death (item 23a) (Type, Print): Peter Ramirez MD 7845 Oakwood Road Suite 201 Glen Burnie, Maryland 21061

State Registrar

31. Data filed (Month, Day, Year): NOV 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Frances Coldren
2. Date of Death Month Day Year: Nov 1 2001
3. Time of Death: 12:40 AM
4a. Facility Name (If not institution, give street and number): 2509 Chestnut Hill Rd
4b. City, Town, or Location of Death: Forest Hill
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 231-18-5806
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 17 1923
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: White Marsh
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5709 Carrington Dr.
10f. Zip Code: 21162
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): Homer Charles Clement
18. Mother's Name (First, Middle, Maiden Surname): Mary Anna Proffitt

19a. Informant's Name/Relationship (Type, Print): Joan Carol Morgan
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2509 Chestnut Hill Rd Forest Hill, Md 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem
Date: Nov 5 2001
20c. Location - City or Town, State: Timonium, Md

21. Signature of Funeral Service Licensee: Krista L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Myeloma — 18 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: dementia

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24e. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) daughters home
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.C. Clouse MD.
29c. License number: D 54937
29d. Date signed (Month, Dey, Yeer): 11/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARTIN C. CLOUSE, MD 6565 N. Charles St, Ste 408, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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RR 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMND ITM#18 PR. F.H. G801 11-05-01 JAB

Reg. No. 2001 35146

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLA MAE CLARK

2. Date of Death (Month, Day, Year): NOVEMBER 02 2001

3. Time of Death: 8:45 PM

4a. Facility Name (If not institution, give street and number): 8229 BALTIMORE AND ANNAPOLIS BLVD.

4b. City, Town, or Location of Death: PASADENA

4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 219-38-8205

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 29 1918

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8229 Baltimore and Annapolis Blvd.

10f. Zip Code: 21122

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed

16b. Kind of Business/Industry: Auto Parts and Towing

17. Father's Name (First, Middle, Last): Alfie McCrackin

18. Mother's Neme (First, Middle, Maiden Surname): ~~Olle Belle~~ OLAR BELL WILLIAMS

19a. Informant's Neme/Relationship (Type, Print): Shirley A. Powers Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code): 8104 Holly Road, Baltimore, Md. 21226

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, crametory or other piece): Cedar Hill Cemetery

Date: 11/06/2001

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee: John F. Williams

22. Neme end Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on aach line.

Approximete Interval Between Onset end Deeth

Immedieta Causa (Final diseese or condition resulting in deeth) e. CARCINOMATOSIS OF THE ABDOMEN — 8 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b. Due to (or es a consequence of):

c. Due lo (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes casa rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be detarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At horna, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) snd manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et tha time, data end place, end dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Wynne MD Attending Doctor

29c. License number: D 21654

29d. Date signed (Month, Day, Year): 11-5-01

30. Neme and addrass of person who completed cause of death (Item 23a) (Type, Print): C-V-CYRIAC. M.D 8021 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Dete filed (Month, Day, Year): NOV 05 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35147

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Doris Emma Critzman	October 27 2001	10:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
502 Hurley Avenue	Arbutus	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-01-3175	1☐M 2☒F	84 Yrs.			Nov 5 1916	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	n/a	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
502 Hurley Avenue	21223	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Beautician	Beauty

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry James Haven	Ada Schach

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ada Harrington / sister	1162 Linden Avenue, Arbutus, Maryland 21227

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Loudon Park Cemetery	10/31/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ann G Zink	Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	5 MINUTES
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. SEVERE CORONARY HEART DISEASE	10 YEARS
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PREVIOUS ANTEROSEPTAL MYOCARDIAL INFARCTION

HYPERTENSION . MULTI-INFARCT DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] ATTENDING PHYSICIAN	D16200	October 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. M. MACHIRAN 720-C MAIDEN CHOICE LA., CATONSVILLE, 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #2 PER FH G801 11/28/01 JH

Certificate of Death

Reg. No. 2001 35148

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Regina M. Campitelli	11	2	~~02~~ 01	1254 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland	Baltimore	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-82-4013	1☐M 2☒F	35 Yrs.					Dec. 13, 1965	Baltimore

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Reisterstown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23 Thames Court	21136	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	2 Yrs College	Systems Analyst	Legg Mason

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Paul A. Campitelli	Doris Jean Bell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Doris J. Campitelli (Mother)	300 Salony Dr. Apt. 308 Reisterstown, Md.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lake View Memorial	11/5/01	Sykesville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Frank B Eline	ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Pulmonary embolus	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lupus nephritis

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.
2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Edward Chung MD	MD 41764351 31154	November 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edward Chung MD, 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	Donna P Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wayne Constantine

2. Date of Death: Month 11 Day 3 Year 2001

3. Time of Death: 12:25 PM

4a. Facility Name (If not institution, give street and number): University of Maryland Med. Center

4b. City, Town, or Location of Death: Baltimore, MD

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 212-58-2304

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9/5/1952

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: OwingsMills

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 107 Cedarmere Road

10f. Zip Code: 21117

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sole Proprietor

18b. Kind of Business/Industry: Painting

17. Father's Name (First, Middle, Last): John Constantine

18. Mother's Name (First, Middle, Maiden Surname): Edith M. Lowson

19a. Informant's Name/Relationship (Type, Print): Karen L. Constantine Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 Cedarmere Road Owings Mills MD 21117

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): All Saints Cemetery

Date: 11/7//01

20c. Location - City or Town, State: Reisterstown, MD

21. Signature of Funeral Service Licensee: Karen B Eline

22. Name and Address of Facility: 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrast, shock, or heert failure. List only one cause on each line.

Approximata Intervat Batwaan Onset and Death

Immediate Causa (Final disease or condition resulting in death): a. liver failure

Dua to (or es a consequence of): b. Hepatitis

Sequantially list conditions, if any, laading to immediata ceusa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequance of): c.

Due to (or as e consequence of): d.

tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Deta of dalivary Month Day Year

Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastrointestinal Bleeding

Renal Failure

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings availabla prior to complation of cause of death? 1 [ ] Yas 2 [X] No

25. Wes casa referred to medical examinar? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Yaer)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Ptace of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To the best of my knowladge, death occurrad at the time, dete and placa, and due to the cause(s) end menner as statad. 2 [ ] **Medical Examinar:** On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and titte of certifier: David Hager MD

29c. License number: Univ of MD - #13085

29d. Date signed (Month, Dey, Year): November 3, 2001

30. Neme and address of person who completad causa of daath (Item 23a) (Typa, Print): David Hager, MD - University of Maryland Medical System

State Registrar

31. Date filed (Month, Dey, Year): NOV 0 5 2001

32. Registrar's Signature: Spark

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-6156-510

MARKELL DAVIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 112601:ITEMS#10e per fh, 23a,27,28a-f per ME G801 ss

Certificate of Death

Reg. No. 2001 35150

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Markell Carr Davis

2. Date of Death Month Day Year: OCTOBER 31,2001

3. Time of Death: 9:24A. M

4a. Facility Name (If not institution, give street and number): UNIVERSITY HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 216-88-6423

6. Sex: [X] 1 M 2 F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10 26 62

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10e. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: [X] 1 Yes 2 No

10e. Street and Number: 4608 1/2 ~~Belleville~~ Belview Ave

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: [X] 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes [X] 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes [X] 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): 1yr

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

18b. Kind of Business/Industry: Computer Science

17. Father's Name (First, Middle, Last): Floyd C. Davis

18. Mother's Name (First, Middle, Maiden Surname): Maria Dickerson

19a. Informant's Name/Relationship (Type, Print): Reginald Davis-Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1222 Stanford Road, Baltimore Md 21207

20a. Method of Disposition: [X] 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park

Date: 11/6/01

20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: Jerome A. Thompson

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE INJURIES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 [X] No 3 Probably 4 Unknown

24a. Was an autopsy performed? [X] 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? [X] 1 Yes 2 No

25. Was case referred to medical examiner? [X] 1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient [X] 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation [X] 6 Could not be determined

28a. Date of Injury (Month, Day Year): 10-31-01

28b. Time of Injury: 8:40a M

28c. Injury at Work? 1 Yes [X] 2 No

28d. Describe how injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Building

28f. Location (Street and Number or Rural Route Number, City or Town, State): 530 N. Carrollton Ave., Baltimore, MD

29a. Certifier (Check only one)

[ ] 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[X] 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Clarke MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): NOVEMBER 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Clarke MD — 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001

32. Registrar's Signature: D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35151

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RALPH W. DORAM

2. Date of Death — Month: October; Day: 30; Year: 2001

3. Time of Death: 8:20 pm

4a. Facility Name *(If not institution, give street end number)*: VA medical Center, Fort Howard, MD 21052

4b. City, Town, or Location of Death: Fort Howard

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-07-1456

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 9-10-1917

9. Birthplace *(State or Foreign Country)*: Kentucky

To Be Completed by Funeral Director

Usual Residence of Decedant

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 3609 ROSEDALE RD.

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Navar Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Giva Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondery (0-12): -12- ; College (1-4or 5+): -0-

16a. Decedent's Usuel Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: CHAIN FENCING

17. Fether's Neme *(First, Middla, Last)*: THOMAS M. DORAM

18. Mother's Neme *(First, Middle, Maiden Sumame)*: BERTHA HANCOCK

19a. Informent's Neme/Reletionship *(Type, Print)*: CARRIE M. DORAM(WIFE)

19b. Meiling Addrass *(Street and Number or Rurel Routa Number, City or Town, State, Zip Coda)*: 3609 ROSEDALE RD. BALTIMORE, MARYLAND 21215

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: ARBUTUS MEMORIAL PARK — Dete: 11-5-2001

20c. Location - City or Town, Stete: BALTIMORE, MARYLAND

21. Signeture of Funeral Service Licensee: Jonatha D. Hisner

22. Name end Address of Feciliity: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet ceused tha daath. Do not enter the mode of dying, such as cerdiec or raspiretory errest, shock, or heart failure. List only ona cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finai diseese or condition resulting in death): e. Prostate Carcinoma — 7 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last:

b. Decubitus ulcers — months

Due to (or es e consequence of):

c. Aortic stenosis — 2 years

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to compiation of ceuse of deeth? 1 [ ] Yes 2 [X] No

25. Was cesa refarred to medicel exeminer? 1 [ ] Yes 2 [X] No

26. Plece of Daath *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Deta of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, and dua to tha ceusa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, death occurred et the time, deta end piece, and dua to tha cause(s) end menner stated.

29b. Signeture end title of certifier: Augustin Chyu. MD

29c. License number: D-18298

29d. Dete signed *(Month, Dey, Yeer)*: 10/31/01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): Augustin chyu, MD 9600 North point Road, Fort Howard, MD 21052

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 05 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Doram, Ralph W. # 1456

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#23a per phys G801 111401 ss

Certificate of Death

Reg. No. 2001 35152

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Daisy Magdalen Evans

2. Date of Death (Month, Dey, Year): November 02 2001

3. Time of Death: 9:109 m

4e. Facility Name (If not institution, give street and number): St Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-34-3668

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): March 25, 1938

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 606 Woodsdale Rd.

10f. Zip Code: 21228

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Abel Dyson

18. Mother's Name (First, Middle, Meiden Surneme): Janie Catherine Thompson

19a. Informant's Name/Relationship (Type, Print): Beverly M. Schatz, daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 606 Woodsdale Rd. Catonsville, MD. 21228

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Bayview Crematory

Date: 11-5-01

20c. Location - City or Town, State: Baltimore, MD

21. Signeture of Funeral Service Licensee: [signature] M01254

22. Name end Address of Facility: Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 1 yr

Due to (or es e consequence of):

b. Pneumonia — 3 weeks

Due to (or es e consequence of):

c. Emphysema — 5 years

Due to (or es e consequence of):

d.

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature] MD

29c. License number: P13597

29d. Date signed (Month, Day, Year): November 02, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Martins T. Ugwu-Dike MD 900 Gator Ave Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): NOV 0 5 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Evans Daisy RR

Division of Vital Records, P.O. Box 68760,

RR 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35153

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA H. EPPS
2. Date of Death (Month, Day, Year): November 01 2001
3. Time of Death: 935 PM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-16-1278
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-5-1923
9. Birthplace (State or Foreign Country): VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1723 N. PAYSON ST.
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -8-; College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: DOMESTIC
17. Father's Name (First, Middle, Last): GEORGE ROBINSON
18. Mother's Name (First, Middle, Maiden Surname): MARY WATSON
19a. Informant's Name/Relationship (Type, Print): TYRONE EPPS(SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8830 HARD KAY WAY BALTIMORE, MARYLAND 21133
20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☒Other (Specify): ENTOMBMENT
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY
Date: 11-8-2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND
21. Signature of Funeral Service Licensee: Joseph D. Hebrew
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Liver failure — 3 days
Due to (or as a consequence of):
b. metastatic colon cancer. — 8 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown
24a. Was an autopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: P. Meemmy.
29c. License number: RES 000
29d. Date signed (Month, Day, Year): November 01 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: Geneva G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35154

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Wampler Fowler
2. Date of Death Month Day Year: Nov 3 2001
3. Time of Death: 9:34 AM
4a. Facility Name (If not institution, give street and number): 3028 Oak Forest Dr.
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-38-8362
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 1 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3028 Oak Forest Dr.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): teacher
18b. Kind of Business/Industry: Baltimore County Schools

17. Father's Name (First, Middle, Last): Luther David Wampler
18. Mother's Name (First, Middle, Maiden Surname): Annie Day

19a. Informant's Name/Relationship (Type, Print): Richard Lewis Fowler, Jr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3028 Oak Forest Dr. Baltimore, Md 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith
Date: Nov. 7 2001
20c. Location - City or Town, State: Rosedale, Md

21. Signature of Funeral Service Licensee: Kenta L Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd Baltimore, MD 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Fetting
29c. License number: D18320
29d. Date signed (Month, Day, Year): 11/5/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. John Fetting 10753 Eagle Rd. Woodstock MD 21093.

State Registrar

31. Date filed (Month, Day, Year): NOV 0 5 2001
32. Registrar's Signature: Bernice D Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35155

ROBERT Norris Fischer
212-22-5312
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Norris Fischer

2. Data of Death — Month: NOV. Dey: 02 Year: 01

3. Time of Death: 12:05 AM

4a. Facility Name *(If not institution, give street and number)*: 3110 Wallford Drive Apt C

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: MARYLAND

Funeral Director

5. Social Security Number: 212-22-5312

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(in yrs. last birthdey)*: 74 Yrs.

If Under 1 Year — Months: Deys:

If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth *(Month, Day, Year)*: Aug. 28, 1927

9. Birthplaca *(Steta or Foraign Country)*: MD.

Usual Residence of Decedent

10a. Stete: Md

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street end Number: 3110 Wallford Drive Apt C.

10f. Zip Code: 21222

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Nevar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 8 yrs. College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Trucking

17. Father's Name *(First, Middle, Last)*: George W. Fischer

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie M. Burmeister

19a. Informent's Neme/Reletionship *(Type, Print)*: Angela M. Fischer wife

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3110 Wallfoed Drive, Apt C. Dundalk, Md. 21222

20a. Method of Disposition: 1 ☐ Buriel 2 ☒ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Bayview Crematory Date: Nov. 6, 2001

20c. Location - City or Town, State: Baltimore City, Md.

21. Signature of Funaral Sarvice Licensee: [signature] MD1096

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

5

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseasa, or complications that ceused the deeth. Do not enter tha moda of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one causa on eech line.

Approximate Interval Between Onset end Death

Immediata Causa (Final disease or condition resulting in deeth)

e. METASTATIC LUNG CANCER — 1 YEAR

Due to (or as e consequance of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE Lung DISEASE

23b. Did tobacco ues contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings availabla prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case refarred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Placa of Death *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Tima of Injury

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Aharon Balanson MD

29c. License number: D0055157

29d. Date signed *(Month, Dey, Year)*: 11/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 9600 North Point Rd. Fort Howard MD 21052

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 05 2001

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35156

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hermina Johanna Furst

2. Data of Death Month / Day / Year: October 29 2001

3. Time of Death: 7:00 p.m.

4a. Facility Name *(If not institution, give street and number)*: 2102 Tred Avon Road

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-01-0523

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Dec. 26, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Rasidance of Decedent

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street and Numbar: 2102 Tred Avon Road

10f. Zip Code: 21221

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yeer or Detas:

13. Was Dacedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indien, Bleck, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elamantary/Secondary (0-12): 10 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Jacob Puhl

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Elizabeth Schaus

19a. Informant's Name/Reletionship *(Type, Print)*: William W. Furst, Jr. (Son)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 2102 Tred Avon Road Essex, Maryland 21221

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of camatery, cramatory or othar placa)*: Hilltop Service Corp. Data: 10/31/2001

20c. Locatlon - City or Town, Stata: Towson, Maryland

21. Signature of Funaral Sarvice Licensaa: Gregory E. [illegible]

22. Nama and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused tha deeth. Do not antar the mode of dying, such es cardiac or respiretory errast, shock, or heart failure. List only ona causa on aach line.

Approximete Intarval Between Onsat and Deeth

Immediete Causa (Finel diseese or condition resulting in daeth)
e. End-stage Dementia — Years

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last
b.
Dua to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.: Pressure ulcers, Oropharyngeal dysphagia, anemia, Hypertension

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings eveilable prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yes 2☑ No

26. Placa of Daeth *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☑ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, dete end place, and due to the causa(s) end menner es steted. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, data and place, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifier: Tom Edmondson MD

29c. License number: D45766

29d. Data signed *(Month, Day, Year)*: October 30, 2001

30. Name end eddress of person who completed causa of daath (Item 23e) (Type, Print): Tom EdmondSon MD 9105 Franklin Square Dr, Ste. 312, Baltimore, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 05 2001

32. Registrar's Signatura: [illegible]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours eftar death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completaly filled in by tha funeral director, pege 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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DHMH 16 Rav 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35157

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Angela Broy Fortson

2. Date of Death (Month, Day, Year): OCTOBER 29 2001

3. Time of Death: 8:59 PM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-52-5396

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 17, 1947

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 342 Leyton Road

10f. Zip Code: 21136

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Edward Broy

18. Mother's Name (First, Middle, Maiden Surname): Ida Olivia Cary

19a. Interment's Name/Relationship (Type, Print): Melissa Broy Fortson / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 342 Leyton Road., Reisterstown, MD 21136

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Chesapeake Crematory

Date: 11/2/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

To Be Completed by Funeral Director

Fortson, Angela

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)
e. RENAL FAILURE — 1 week

Due to (or es e consequence of):

Sequantially list conditions, if eny, leeding to immediate ceusa. Entar Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last
b. MULTIPLE MYELOMA — 2 YRS

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Laryngeal Edema

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD.

29c. License number: D27730

29d. Date signed (Month, Day, Year): 10/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY COHEN, MD. 6569 N. CHARLES ST. BALTO. MD. 21204

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001

32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35158

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Alexander Fee
2. Dete of Deeth: Month October Dey 30 Year 2001
3. Time of Deeth: 23:57
4e. Facility Neme (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Sociel Security Number: 213-55-8960
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthdey): 2 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): APR.13,1999
9. Birthplece (Stete or Foreign Country): MD

Usuel Residence of Decedent

10a. Stete: MD
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 707 STONE BARN ROAD
10f. Zip Code: 21286
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Reca - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): NONE; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): NONE
16b. Kind of Business/Industry: NONE

17. Fether's Neme (First, Middle, Last): EDWIN G. FEE JR.
18. Mother's Neme (First, Middle, Maiden Surneme): LISA BARKAN
19e. Informent's Neme/Reletionship (Type, Print): EDWIN G. FEE, JR. / FATHER
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 707 STONE BARN ROAD - TOWSON, MD 21286

20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Plece of Disposition (Neme of cemetery, crematory or other piece): OHEB SHALOM MEMORIAL PARK
Dete: 11/2/01
20c. Location - City or Town, Stete: REISTERSTOWN, MD

21. Signeture of Funerel Service Licensee: Michael Krugen
22. Neme and Address of Feciility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	Systemic Inflammatory Response Syndrome	4 days
Due to (or es e consequence of): b.	Lymphoproliferative Disease	7 weeks
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Last Due to (or es e consequence of): c.	Biliary Atresia	2 1/2 years
Due to (or es e consequence of): d.		

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

Multi Organ System Failure
Liver Transplantation

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Plece of Deeth (Check only one): Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es stated. 2 [ ] **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Amal Murarka MD
29c. License number: D0052998
29d. Date signed (Month, Dey, Yeer): October 30 2001

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Amal Murarka MD. 600 N. Wolfe St., Blalock 904, Baltimore, MD 21287

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 0 5 2001
32. Registrer's Signeture: Debra D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-6129-005
mnmr
Harry R. Gorge, II

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35159

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar	3. Tima of Death
Harry R. Gorge, Jr.	October 30, 2001	6:15 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7608 Old Battle Grove Road	Dundalk	Baltimore

Funeral Director

5. Social Security Number	8. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foraign Country)
220-03-6610	1☒M 2☐F	80 Yrs.			Sept. 7,1921	Maryland

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
7608 Old Battle Grove Road	21222	United States

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, Whita, atc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yas 2☐No If Yes, Giva Yaar or Dates:	1☐Yas 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highast grade completed)		16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
9 Years		Welder/Crane Operator	Steel Industry

17. Father's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middla, Maiden Sumama)
Harry R. Gorge, Sr.	Not Known

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Mr. Harry Gorge, III (Son)	9312 West Flora Street Tampa, FL 33615

20a. Method of Disposition	20b. Place of Disposition (Nama of cemetary, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1☒Burial 2☐Cremation 3☐Ramoval from State 4☐Donation 5☐Other (Specify)	Crownsville V.A. Cem.	11/5/2001	Crownsville, MD

21. Signature of Funaral Service Licensee: Stephanie Hansen

22. Nama and Addrass of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one ceuse on each lina.

		Approximate Intarval Batwaan Onsat and Daath
Immediata Causa (Finaf disease or condition resulting in death)	a. Asphyxiation	
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Dua to (or as a consequence of):	
	c. Dua to (or as a consequence of):	
	d. Dua to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pregnancy	23d. Data of dalivary Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Othar (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceuse given in Part I.

Multiple blunt force and cutting wounds

23a. Did tobacco usa contribute to tha causa of daath?	24a. Was an autopsy performad?	24b. Wara autopsy findings availabla prior to compliation of causa of death?
1☐Yas 2☒No 3☐Probably 4☐Unknown	1☒Yas 2☐No	1☒Yas 2☐No

25. Was cese referred to medical examiner?	26. Placa of Daath (Chack only ona)	
☒Yas 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Othar: 4☐Nursing Homa 5☐Rasidence 6☒Othar (Specify) at scene

27. Manner of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not ba datarmined	Found 10/30/01	unknown M	1☐Yas 2☒No	Subject was asphyxiated by manual strangulation and blockage of airway by pieces of cloth.

28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify)	28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata)
Residence	7608 Old Battle Grove Rd Baltimore County, Maryland

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated.
2☒ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Yaar)
J. M. Th fm	O.C.M.E.	October 31, 2001

30. Nama and addrass of person who completed causa of daath (Item 23a) (Typa, Print)
Stephen Badentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data Filed (Month, Day, Yaar): NOV 05 2001

32. Registrar's Signature

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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RR 4+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35160

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVANTHIA GEORGAKIS
2. Date of Death (Month, Day, Year): OCTOBER 31, 2001
3. Time of Death: 11:20 PM
4a. Facility Name (If not institution, give street and number): STELLA MARIS, INC
4b. City, Town, or Location of Death: TIMONIUM, MD
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 085-18-5352
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/27/1911
9. Birthplace (State or Foreign Country): Greece

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4613 E. Joppa Road
10f. Zip Code: 21128
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Midwife
16b. Kind of Business/Industry: Church
17. Father's Name (First, Middle, Last): Peter Demetrius
18. Mother's Name (First, Middle, Maiden Surname): Mary Yiannaki
19a. Informant's Name/Relationship (Type, Print): Antonios Georgakis
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4613 E. Joppa Road Perry Hall, Maryland 21128
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenfield Cemetery
Date: 11/5/01
20c. Location - City or Town, State: Hempstead New York
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. End stage renal disease

Due to (or as a consequence of): Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. _____

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerosis

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: 019505
29d. Date signed (Month, Day, Year): 11.2.01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDDIE NAKHUDA, M.D. 2300 Dulaney Valley Rd. Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: [signature] D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35161

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lois E. Gilbert

2. Date of Death Month / Day / Year: November 02 2001

3. Time of Death: 8:30AM M

4a. Facility Name *(If not institution, give street and number)*: 250 E. Padonia Rd.

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-20-9538

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7-10-1929

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 250 E. Padonia Road

10f. Zip Code: 21093

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Francis E. Boone, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Kathleen Wagner

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Jack H. Gilbert (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 250 E. Padonia Road, Timonium, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 11-6-01

20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: ▶ Wallace S. Brooks, Jr

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO PULMONARY COLLAPSE — SECONDS

Due to (or as a consequence of):

b. REFRACTORY HEART FAILURE — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ATRIAL FIBRILLATION — WEEKS

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

METASTATIC PANCREATIC CANCER

DEPRESSION

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael D. Pressel, M.D.

29c. License number: D40547

29d. Date signed *(Month, Day, Year)*: 11/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL D. PRESSEL, 6565 N. CHARLES ST., SUITE 305, PPE, TOWSON, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 0 5 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

6 29 pm

Glazier, Pauline October 31, 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35162

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAULINE GLAZIER
2. Date of Death (Month, Day, Year): OCTOBER 31, 2001
3. Time of Death: 6:20 PM
4e. Facility Name (If not institution, give street and number): HOSPICE OF BALTIMORE - GILCHRIST CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-03-5124
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT.2,1911
9. Birthplace (State or Foreign Country): ENGLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2500 W. BELVEDERE AVENUE #319
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESLADY
16b. Kind of Business/Industry: RETAIL

17. Father's Name (First, Middle, Last): PINCUS KANDEL
18. Mother's Name (First, Middle, Maiden Surname): MIRIAM MEHLMAN

19a. Informant's Name/Reletionship (Type, Print): BARRY STUART GLAZIER / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 SPRUCE COURT - OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FOREST LAWN CEMETERY
Date: 11/2/01
20c. Location - City or Town, State: NORFOLK, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. colon cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN, DM, CAD,

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☒ Other (Specify) hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D0051926
29d. Date signed (Month, Day, Year): October 31, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Gordan 6565 N. Charles St Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

RKD

01-6166-510

NORMAN HOPKINS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35163

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Norman Hopkins	OCTOBER 31, 2001	2:30P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5915 RADECKE AVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs, last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
183-48-6397	1☒M 2☐F	44 Yrs.			May 3, 1957	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Balto.	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5915 Radecke Ave	21206	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Mixer	painting

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Francis Hopkins	Juanita Ball

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michelle Faulcon sister	3780 Bonniview Ave. Balto.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Crownsville Vet Cem.	11/8/2001	Anne Arundel, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Carlton C. Douglas	Carlton C. Douglas Funeral Service P.A. 1701 McCulloh St. Balto. Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] M.D.	O.C.M.E.	NOVEMBER 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. CARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	[signature] G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35164

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Larry Darnell Hopson
2. Date of Death (Month, Day, Year): Nov. 01, 2001
3. Time of Death: 4:20a M
4a. Facility Name (If not institution, give street and number): 960 Ashnridge Drive
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-66-0874
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 45 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-10-56
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Essex
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 960 Ashbridge Drive
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th Grade
College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mover
18b. Kind of Business/Industry: Moving Company

17. Father's Name (First, Middle, Last): Joseph Hopson
18. Mother's Name (First, Middle, Maiden Surname): Ethel Epps

19a. Informant's Name/Relationship (Type, Print): Denise Hopson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 960 Ashbridge Drive Essex, Maryland 21221

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Gardens
Date: 11-05-2001
20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: ▶ Gladys Ware
22. Name and Address of Facility: Baltimore, Maryland 21202 March F.H. 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC CARCINOID STOMACH CANCER — Approximate Interval Between Onset and Death: 1 YR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

tF FEMALE:
23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Joyce E. King MD
29c. License number: D42986
29d. Date signed (Month, Day, Year): 11/05/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOYCE E. KING, M.D. 9101 FRANKLIN SQUARE DR # 205 BALTIMORE MD 21237

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: ▶ Jeanne G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 19b PER FH G800 11/05/01 RR

Certificate of Death

Reg. No. 2001 35165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Catherine M. Hagin	October 31, 2001	12:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-34-9468	1☐ M 2☒ F	64 Yrs.			February 7, 1937	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8550 Harris Avenue	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade	N/A	School Crossing Guard	School System

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Julius Anderson	Catherine Gruenner

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James W. Hagin, Jr. /Son	3511 Rosekemp Avenue Baltimore Maryland ~~21234~~ 21214

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Parkwood Cemetery	11/3/01	Baltimore Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Christina L. Hilton ▶ Christina L. Hilton	Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Acute Leukemia	months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	October 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	▶

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

October 31, 2001 12:20am

Catherine M. Hagin RR

RR 10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 35166

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Joseph B. Hofmann, Jr.	October 29, 2001	3:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Hospital	Baltimore	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-56-4738	1 [X] M 2 [ ] F	50 Yrs.			11/25/1950	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4322 Annapolis Road	21227	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Postal Supervisor	Federal Goverment

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph B. Hofmann, Sr.	Leah K. Claycomb

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John S. Hofmann / Brother	3220 Wellington Street, Philadelphia, Pa. 19149

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Loudon Park Cemetery	11/2/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
8/23/01	UNK M	1 [ ] Yes 2 [X] No	Driver in auto accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): Washington Blvd/Sulfur Spring RD

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature]	29c. License number	29d. Date signed (Month, Day, Year)
	P14152	October 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N. McQuay, MD, 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	[signature] D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35167

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Milton Francis Jakubik

2. Date of Death (Month, Day, Year): November 1 2001

3. Time of Death: 11:30 PM

4a. Facility Name *(If not institution, give street and number)*: Keswick Multi- Care Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-07-1055

6. Sex: 1 ☐ M 2 ☐ F — X

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: December 19, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: X ☐ Yes 2 ☐ No

10e. Street and Number: 1922 Burnwood Road

10f. Zip Code: 21239

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No — Specify:

14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Longshoreman

16b. Kind of Business/Industry: Shipping

17. Father's Name *(First, Middle, Last)*: Walter Jakubik

18. Mother's Name *(First, Middle, Maiden Surname)*: Aleksandra Miodzsuewski

19a. Informant's Name/Relationship *(Type, Print)*: Michael Jakubik- Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1303 Northview Road Baltimore, Maryland 21218

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Rosary Cemetery

Date: 11/5/01

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Heather Cain — Heather Cain

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Alzheimer's disease — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Isabelle MacGregor MD

29c. License number: D13657

29d. Date signed *(Month, Day, Year)*: November 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ISABELLE MACGREGOR, 700 W. 40TH STREET, BALTIMORE, MD 21211

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 05 2001

32. Registrar's Signature:

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

RR

RR 5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35168

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy T. Jones

2. Date of Death: Month Oct, Day 30, Year 2001

3. Time of Death: 5:45 PM

4a. Facility Name (If not institution, give street and number): 8440 Grove Angle Road

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 216-30-6352

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 6 1924

9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8440 Grove Angle Road

10f. Zip Code: 21043

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Lacey Treadway

18. Mother's Name (First, Middle, Meiden Surname): Thelma (Unknown)

19a. Informant's Name/Relationship (Type, Print): Sharon Jones / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8430 West Grove Road, Ellicott City, Maryland 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 11/2/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Heather A. Brown

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dementia — 2 years

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Type II

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sapna Kuehl

29c. License number: D56473

29d. Date signed (Month, Day, Year): November 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sapna Kuehl, M.D. 900 CATON AVE., BOX 060, BALTIMORE, MD21229

State Registrar

31. Date filed (Month, Day, Year): NOV 0 5 2001

32. Registrar's Signature: ▶ D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-6155-005
B.K.S Robert Jackson
UNKNOWN 01-301

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMENDED 112101:ITEM#23ptII per ME 0801 ss

Reg. No. 2001 35169

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT JACKSON
2. Date of Death Month Day Year: Oct. 31, 2001
3. Time of Death: 0910 A M
4a. Facility Name (If not institution, give street and number): 6205 FALLS ROAD
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-32-6210
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-19-1938
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3229 INGLESIDE AVE.
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): -12-
College (1-4or 5+): -4-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
18b. Kind of Business/Industry: LINGUISTICS

17. Father's Name (First, Middle, Last): LESLIE JACKSON SR.
18. Mother's Name (First, Middle, Maiden Surname): MARTHA CURBEAM

19a. Informent's Name/Reletionship (Type, Print): FRANCINE JACKSON(WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3229 INGLESIDE AVE. BALTIMORE, MARYLAND 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ENTOMBMENT
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK
Date: 11-6-2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Jonatha J. Thomas
22. Name and Address of Facility: PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one cause on eech line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypothermia complicating Hypertensive Cardiovascular Disease
Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. Due to (or es e consequenca of):
c. Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnency 4 ☐ Pregnent et time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.
Alzheimer's disease DEMENTIA

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☒ Unknown
24a. Was en autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Menner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year): 10/31/01
28b. Time of Injury: 8:45 A M
28c. Injury et Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: EXPOSURE TO COLD ENVIRONMENTAL temperatures
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): outside
28f. Location (Street and Number or Rural Route Number, City or Town, State): 6205 Falls Road Towson, MD

29e. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated. 2 ☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier: J. M. Titus
29c. License number: O.C.M.E
29d. Date signed (Month, Dey, Year): NOV. 1, 2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Jack M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer): NOV 05 2001
32. Registrar's Signeture: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35170

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Maxine Kirkley
2. Data of Death (Month, Day, Year): November 3, 2001
3. Time of Death: 8:35 A.M.
4a. Facility Neme *(If not institution, give street end number)*: Continuum Care
4b. City, Town, or Location of Deeth: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 310-12-6434
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: July 8, 1920
9. Birthplace *(State or Foreign Country)*: Indiana

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Carroll
10c. City, Town or Locetion: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Streef and Number: 7200 3rd Ave. Apt. B205
10f. Zip Code: 21784
10g. Citizen of What Country?: United States

11. Marital Stafus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Roy M. Smith
18. Mother's Neme *(First, Middle, Maiden Surname)*: Rella M. Mooneyham

19e. Informent's Neme/Reletionship *(Type, Print)*: James S. Kirkley / Husband
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7200 3rd Ave. Apt B205 Sykesville, MD 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donefion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Glen Haven Memorial Pk. Dated: Nov. 6, 2001
20c. Location - City or Town, Stete: Glen Burnie, MD

21. Signature of Funeral Service Licensea: [signature]
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Pert1. Enter the disaasa, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. Lisf only ona cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Final diseese or condition resulting in deeth)
e. New onset seizures
Due to (or as a consequence of):
b. Atrial fibrillation
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events raaulting in death) Last
Due to (or as e consequence of):
c. (L) LE DVT
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but nof resulting in tha undarlying cause given in Part I.: Alzheimer's Dementia GERD

23b. Did tobacco uss contributs to the cause of death? 1☐ Yss 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signafure and title of certifier: [signature] S. Sivaraj MD
29c. License number: 30119
29d. Date signed *(Month, Day, Year)*: 11/5/01

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): SHAHIDA SIDDIQI 6212 SYKESVILLE ROAD MD 21784

State Registrar

31. Date filed *(Month, Dey, Year)*: NOV 05 2001
32. Registrer's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-6206-510
B.K.S
EVELYN LINDY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 111401:ITEMS#23a,ptII,27 per ME 6801 ss

Certificate of Death

Reg. No. 2001 35171

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Evelyn Rene Lindy	OCT. 31, 2001	11:50 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-62-9688	1☐M 2☒F	39 Yrs.			Sept. 9, 1962	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
3354 W. Belvedere Avenue	21215	USA

11. Maritat Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th grade		Entrepreneur	Self Employed

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Sumame)
Charles Lindy	Cardenia Smith

19a. Informant's Neme/Retetionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cardenia Lindy-Giles /Mother	3354 W. Belvedere Avenue Baltimore,Maryland 21215

20e. Method of Disposition	20b. Ptace of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donation 5☐Other (Specify)	Mt. Zion Cemetery	11/7/01	Baltimore,Maryland

21. Signeture of Funeral Service Licensee	22. Neme and Address of Facility
Gary Harris	Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore,Maryland 21215

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
tmmediate Cause (Finat diseese or condition resulting in death)	a. END STAGE RENAL DISEASE	
Sequentially list conditions, if any, teading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or es e consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC NARCOTISM; BRONCHIAL ASTHMA

23e. Did tobacco use contribute to the cause of death?	24e. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probebly 4☒Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and ptace, and due to the cause(s) end menner es stated.
2☒ **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Pestaner MD	O.C.M.E	NOV. 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	Penny P. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2001 35172

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Michael	Todd	Lane	October 29, 2001	0913 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Union Memorial Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
206-54-5825	X 1 M 2 F	36 Yrs.			07 25 65	PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Dauphin	Harrisburg	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2712 Waldo Street	17110	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married X 2 Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	na	Caterer	Community College

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Alfred Ned Chisolm	Doris Jean Lane

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alfred E. Lane Sr.	62 Rotherham Lane, Hampton, VA 23666

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Yorktowne Crematory	11/6/01	York, PA 17404

21. Signature of Funeral Service Licensee: Jerome A. Thompson

22. Name and Address of Facility: March I/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — one month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aquired Immune Deficiency Syndrome — Two months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Alveolar Proteinosis

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 X Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Dr Maims	AU417643SM13876	OCTOBER, 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas J. Maime, M.D. 201 East University Parkway Baltimore MD 21218-2895

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Mary	Leshko	October 29, 2001	12:14 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Ctr.	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
171-01-3395	1☐M 2☒F	94 Yrs.			Feb. 8, 1907	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Edgemere	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3215 Lynch Road	21219	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8 Years		Cook	High School Cafeteria

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Michael Zapotosky	Mary Facak

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Helen Leshko (Daughter)	3215 Lynch Road Edgemere, Maryland 21219

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. John Byzantire Cath. Cem.	11/3/2001	Hazelton, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephanie Massey	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic coronary disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Hypercholesterolemia	
	c. Due to (or as a consequence of): Diabetes	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D-41399	10/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Theodore Stevens 1005 North Pt. Blvd. Suite 724 Baltimore, MD 21222

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Jane Ludwig	November 01 2001	9:15PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris	Timonium	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-14-5698	1☐M 2☒F	79 Yrs.			Jan 6, 1922	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Cockeysville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3 Wimpole Court	21030	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk	Dentist Office

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Andrew J. Ludwig	Mary D. Pierpoint

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruth Manley / sister	3 Wimpole Court; Cockeysville, MD 21030

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	New Cathedral Cem	11/6/01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Peter U Clay	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	Hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bipolar Schizoaffective Disorder

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 8☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Ernestine Wright, MD	D52740	November 2nd 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ernestine Wright, MD Fairhaven Nursing Home Sykesville, Md.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 5 2001	▶ D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35175

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Georgina Lyle			November 1st 2001	7:45PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
University of Maryland Medical Center	Baltimore		N/A	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-68-4400	1☐M 2☒F	43 Yrs.			1-26-1958	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8 FREEMONT AVE.	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-	-0-	NURSING ASSISTANT	MEDICAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LEONARD LYLE	KAY WRIGHT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PHYLLIS REESE(COUSIN)	3301 BARRINGTON RD. BALTIMORE, MARYLAND 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	ARBUTUS MEMORIAL PARK	11-6-2001	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jonathan J. Hibner	PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arrythmia	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Serous Carcinoma of ovary	6months
	Due to (or as a consequence of): c. human immunodeficiency virus	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☒Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	26c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Marcia Cort Emergency Department Attendy	D0056240	November 1st 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marcia Cort U.M.M.S. 22 S. Greene St. Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	▶ Geneva D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35176

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Clara	Mason	Mobley	November 2 2001	00 50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SAINT AGNES HOSPITAL	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
242-26-5934	1 ☐ M 2 ☒ F	86 Yrs.			02 07 15	NC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
609 Brisbane Road	21229	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12th grade	4 yrs	Montibello State Hosp.	State of Maryland

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
William Mason	Anna Ervin

19a. Informant's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Mobley-Son	609 Brisbane Road, Baltimore, Md 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	King Memorial Park	11/10/01	Randallstown, Md

21. Signature of Funeral Service Licensee: Joseph R. Krampf

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Renal Failure	Days
Due to (or as a consequence of): b.	Congestive Heart Failure	Weeks
Due to (or as a consequence of): c.	Coronary Artery Disease	Years
Due to (or as a consequence of): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Dete of delivery Month / Day / Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] PHYSICIAN	P 15633	November 2 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
LAURA D KHANDAGLE 900 CATON AVENUE BALTIMORE MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 5 2001	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

NAME CLARA MOBLEY

a

b

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. no. 2001 35177

Physician /Medical Examiner

1. Decedant's Neme (First, Middle, Last)	2. Dete of Death Month Day Yaar	3. Time of Death
Brigitte Miller	November 4, 2001	5:05 P M

4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deeth
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sax	7. Age (In yrs. last birthdey)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Deta of Birth (Month, Day, Yeer)	9. Birthplece (State or Foreign Country)
213-40-1766	1☐M 2☒F	71 Yrs.			February 27, 1930	Germany

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Anne Arundel	Glen Burnie	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24 New Jersey Avenue N.W.	21061	United States

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yas 2☐No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT usa ratired)	16b. Kind of Business/Industry
Elamantary/Sacondary (0-12)	College (1-4or 5+)		
12		Appliance Salesperson	Retail

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middla, Maidan Sumame)
Herman Schroeder	Frieda Zimmerman

19a. Informant's Name/Reletionship (Type, Print)	19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)
Rita Trice / Daughter	24 New Jersey Avenue N.W. Glen Burnie Maryland 21061

20a. Method of Disposition	20b. Place of Disposition (Nama of camatary, cramatory or othar place)	Date	20c. Location - City or Town, State
1☒Boriel 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Crownsville MD Vet. Cemetery	November 7 2001	Crownsville, Maryland

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
▶	Kirkley-Ruddick Funeral Home P.A. 421 Crain Highway S.E. Glen Burnie, Maryland 21061

Physician /Medical Examiner

23a. Part1. Entar the diseese, or complicetions thet caused tha daeth. Do not enter the moda of dying, such as cardiac or respiretory errest, shock, or haart failura. List only one cause on aach line.

Approximata Interval Betwaen Onsat and Death

Immediete Causa (Final disaase or condition resulting in daath)

a. Chronic Obstructive pulmonary disease Exacerbation — ≥1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseesa or injury that initiated avents resulting in death) Last

b. Hypertension — ≥1 yr

Due to (or as a consequence of):

c. Dementia — ≥1 yr.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedant pregnent in the past 12 months?	23c. If yas, outcome of pregnancy	23d. Data of dalivary Month Day Year
1☐Yas 2☐No 9☐Unknown	1☐Live birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Othar (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

23e. Did tobacco usa contribute to the cause of daath? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to complation of causa of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical axaminar?	26. Placa of Death (Chack only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Naturel 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☒**Certifying Physician**: To tha bast of my knowledge, daath occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, data and piece, and dua to the causa(s) and mannar stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Yaar)
▶ MD	D40519	11-4-01

30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print)

Marta M. Nusaibeh

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signature
NOV 05 2001	▶ Barbara G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35178

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Elsie	Marsh	November 1, 2001	8:45AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2921 Montebello Terrace	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
201-01-7728	1☐M 2☒F	83 Yrs.					August 26, 1918	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2921 Montebello Terrace	21214	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Heidingsfelder	Mary Mosmeier

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda L. Knott - Daughter	2921 Montebello Terrace Baltimore, Maryland 21214

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BelAir Memorial Gardens	11/6/01	BelAir, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Heather Cain	Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARRYTHMIA	10 MIN.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. COPD	10 year.
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☒Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D44604	11/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL SUTER MD 8100 HARFORD ROAD BALT MD 21234

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	▶

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

RR

RR 8

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35179

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alfonsia Mitchell

2. Date of Death Month Day Year: NOV. 2, 2001

3. Time of Death: 10:45 a.m.

4a. Facility Name (If not institution, give street and number): St. Elizabeth Nursing Home

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-09-4479

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 7 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 225 S. Gilmore

10f. Zip Code: 21223

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Quality Control

16b. Kind of Business/Industry: Manufacturer

17. Father's Name (First, Middle, Last): Benedict Plungis

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Simmons

19a. Informant's Name/Relationship (Type, Print): Patricia Skane/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1642 S. Charles St., Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Most Holy Redeemer Cem.

Date: 11-5-2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. metastatic carcinoma of unknown primary — 1 month

Due to (or as a consequence of):

b. malignant pleural effusion — 1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. COPD — 10 years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶

29c. License number: 052746

29d. Date signed (Month, Day, Year): Nov. 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Yelena Sprik, 720 Meadow Choice Lane, Baltimore MD 21220

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001

32. Registrar's Signature ▶ Brenda D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35180

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harry Metnick

2. Date of Death — Month: November; Day: 01; Year: 2001

3. Time of Death: 4:50 PM

4a. Facility Name *(If not institution, give street and number)*: Levindale Geriatric Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 135-16-7310

6. Sex: XX 1 M 2 F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: JUN. 19, 1913

9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 6310 GREENSPRING AVENUE #403

10f. Zip Code: 21209

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 XX Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): ; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CONTRACTOR

16b. Kind of Business/Industry: CLOTHING

17. Father's Name *(First, Middle, Last)*: JACK METNICK

18. Mother's Name *(First, Middle, Maiden Surname)*: ROSE ROTHSTEIN

19a. Informant's Name/Relationship *(Type, Print)*: SYLVIA METNICK / WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6310 GREENSPRING AVENUE #403 - BALTIMORE, MD 21209

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BALTIMORE HEBREW CEM.

Date: 11/2/01

20c. Location - City or Town, State: REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: Michael Bruce

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anorexia — 1 month

Due to (or as a consequence of):

b. Dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XX Unknown

24a. Was an autopsy performed? 1 Yes 2 XX No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 XX No

26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 X Nursing Home 5 Residence 8 Other *(Specify)*

27. Manner of Death: 1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D55391

29d. Date signed *(Month, Day, Year)*: November 02, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ming Yi 2434 West Belvedere Avenue, Baltimore Maryland 21215

State Registrar

31. Date Filed *(Month, Day, Year)*: NOV 05 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 35181

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN LEWIS NOBLE

2. Date of Death: Month 11 Day 2 Year 01

3. Time of Death: 0700 M

4a. Facility Name (If not institution, give street and number): St Agnes Hospital

4b. City, Town, or Location of Death: Baltimore, MD

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 136-26-7555

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 07, 1938

9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 XX Yes 2 ☐ No

10e. Street and Number: 3314 Elgin Avenue

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:

14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12th

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Federal Employee

18b. Kind of Business/Industry: Social Security Administration

17. Father's Name (First, Middle, Last): John William Noble

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Eaden

19a. Informant's Name/Relationship (Type, Print): Gwendolyn L. Noble-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3314 Elgin Avenue Baltimore, MD 21216

20a. Method of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Hill Cem.

Date: 11/10/01

20c. Location - City or Town, State: Lynchburg, VA.

21. Signature of Funeral Service Licensee: Michael Zyler

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsel and Death

Immediate Ceuse (Finel disease or condition resulting in deeth)

a. Atherosclerotic Cardiovascular Disease — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time ot deeth 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.: Hyperglycemia

23e. Did tobacco use contribute to the cause of death? 1 XX Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 XX No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 XX No

26. Place of Deeth (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 XX DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0027315

29d. Date signed (Month, Day, Yeer): November 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. L Fiydenberg MD St. Agnes Hospital

State Registrar

31. Date filed (Month, Day, Year): NOV 0 5 2001

32. Registrar's Signature: Denise D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME Noble, John

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2001 35182

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): William Henry Owens JR
2. Data of Death — Month: November Dey: 01 Year: 2001
3. Time of Death: 2:05 PM
4a. Facility Nama (If not institution, give street and number): Levindale Geriatric Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-01-5075
6. Sex: 1☒ M 2☐ F
7. Aga (In yrs. last birthday): 90 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): March 27, 1911
9. Birthplace (State or Foraign Country): Maryland

Usual Residence of Decedent

10a. Stata: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3816 Barrington Road
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A
11. Maritel Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:
13. Wes Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Bleck, Whita, atc. Specify: Black
15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Entrepreneur
16b. Kind of Businass/Industry: Entertainment
17. Father's Nama (First, Middle, Last): William Henry Owens, Sr.
18. Mother's Name (First, Middle, Maiden Surnama): Mary Keyes
19a. Informent's Name/Ralationship (Type, Print): Renold Dana Owens / Son
19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 3816 Barrington Road Baltimore, Maryland 21215
20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or othar place): King Memorial Park
Dete: November 6, 2001
20c. Location - City or Town, Stata: Baltimore County, Maryland
21. Signeture of Funarel Service Licensee: Maggalen Gilmore Henson
22. Name end Address of Facility: Maggalean Gilmore Henson, Mortician 5240 Reisterstown Road Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Entar tha disaase, or complicetions that caused the deeth. Do not entar tha mode of dying, such es cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on aach line.

Approximate Intarval Batween Onset and Deeth

Immediata Causa (Final disaasa or condition resulting in death):
a. Chronic Obstructive Pulmonary Disease — years
Dua to (or as a consequance of):
Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Dua to (or as a consequance of):
c.
Due to (or es e consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Residanca 6☐ Othar (Specify)

27. Mennar of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigetion 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end piece, and due to the cause(s) and mannar stated.

29b. Signatura end title of certifier: M.D.
29c. License number: D55391
29d. Data signed (Month, Day, Year): November 1, 2001

30. Nema and addrass of parson who complated causa of death (Item 23a) (Type, Print): Ming Yi 2434 West Belvedere Avenue, Baltimore Maryland 21215

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signatura: Bernice D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35183

Emma PH; L.PS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emma Lee Phillips
2. Date of Death Month/Day/Year: November 1 2001
3. Time of Death: 5:20pm
4a. Facility Name (If not institution, give street and number): Mariner Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-20-8196
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02 05 23
9. Birthplace (State or Foreign Country): NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XX Yes 2 ☐ No
10e. Street and Number: 966 North Franklintown Road
10f. Zip Code: 21216
10g. Citizen of What Country? U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed XX Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Laborer
16b. Kind of Business/Industry: Gulf State Plastic
17. Father's Name (First, Middle, Last): Thomas Coley
18. Mother's Name (First, Middle, Maiden Surname): Pearlie Coley
19a. Informant's Name/Relationship (Type, Print): Thelma L. Smith-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2952 Beaverwood Lane, Weaton, Md 20906
20a. Method of Disposition: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 11/6/01
20c. Location - City or Town, State: Baltimore, Md
21. Signature of Funeral Service Licensee: Irma A. Thompson
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harold Bob
29c. License number: D15872
29d. Date signed (Month, Day, Year): November 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HAROLD BOB MD 25 Main Street Reisterstown Maryland 21136

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: Geneva D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 35184

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katherine Veronica Powers
2. Date of Death (Month, Day, Year): November 2, 2001
3. Time of Death: 4:15 AM
4a. Facility Name (If not institution, give street and number): Lorien Frankford Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-32-9576
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/11/1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4707 Greenhill Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Matron
16b. Kind of Business/Industry: Baltimore City Jail
17. Father's Name (First, Middle, Last): Joseph Kelly
18. Mother's Name (First, Middle, Maiden Surname): Nellie Cassidy
19a. Informant's Name/Relationship (Type, Print): Dolores Brush/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4707 Greenhill Avenue Baltimore, Maryland 21206
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery
Date: 11/6/01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ANEMIA	DAYS
Due to (or as a consequence of): b.	POST-MENOPAUSAL VAGINAL BLEEDING	WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	SUSPECTED ENDOMETRIAL CA	MONTHS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BLADDER CA; CACHEXIA (SEVERE AND CHRONIC); ASCVD; CARDIOMYOPATHY; COPD; DEMENTIA; CHRONIC ANEMIA.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: 041291
29d. Date signed (Month, Day, Year): November 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JONATHAN GITTER, M.D. 21 CROSSROADS DR. #330 OWINGS MILLS 21117

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: Jeanne D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35185

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Willie B. Rushing

2. Date of Death Month Day Year: October 31, 2001

3. Time of Death: 4:00 P.M

4a. Facility Name *(If not institution, give street and number)*: Future Care Canton Harbor

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-28-0615

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 25, 1924

9. Birthplace *(State or Foreign Country)*: Mississippi

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 59 Akin Circle

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Marital Status: Unknown
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW2

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 5th grade
College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Panda Transport

17. Father's Name *(First, Middle, Last)*: Albertia Rushing

18. Mother's Name *(First, Middle, Maiden Surname)*: Stella

19a. Informant's Name/Relationship *(Type, Print)*: Melissa Rushing/ Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 466 Glen Mar Road Glen Burnie, Maryland 21061

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crownsville Veterans Cemetery — 11/6/01

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Jerry Harris

22. Name and Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Maryland 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. END STAGE DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CANCER PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D16619

29d. Date signed *(Month, Day, Year)*: NOV. 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. VERGARA-SOARES 1300 S. ELLWOOD BALTIMORE, MD. 21224

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 0 5 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35186

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean Annette Rosendale

2. Date of Death: Month NOV Day 1 Year 2001

3. Time of Death: 1600

4a. Facility Name (If not institution, give street and number): Levindale Hebrew Geriatric Center and Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 175-12-6357

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 18, 1920

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5927 Theodore Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Manager

16b. Kind of Business/Industry: Bank of America

17. Father's Name (First, Middle, Last): William Brownlee

18. Mother's Name (First, Middle, Maiden Surname): Emily Simandl

19a. Informant's Name/Relationship (Type, Print): John Rosendale, Sr.- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5927 Theodore Avenue Baltimore, Maryland 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 11/5/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Cain

Heather Cain

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic Encephalopathy

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pressure Sores

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Debra S Weinstein MD

29c. License number: D73767

29d. Date signed (Month, Day, Year): 11/2/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Debra S Weinstein MD 2434 W. Belvedere Ave, Balto, Md 21215

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

RR Rosendale, Jean

RR 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
William	Henry	Robinson, Jr.	Nov. 1, 2001	3:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care-HCR-Towson	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
721-18-4919	1☒M 2☐F	75 Yrs.			May 9, 1926	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Towson	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
500 Virginia Ave. Apt. 1212	21286	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Teacher	Baltimore County Schools

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Henry Robinson, Sr.	Nancy Powers

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Larry Chase/godson	8-E Fitzgerald Ct. Baltimore, MD 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	11/3/01	Towson, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. liver cancer — Due to (or as a consequence of): — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD.	D41104	11.01.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ted Houk MD 7825 York Rd Towson MD 21204.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	[signature] D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35188

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert Thomas Shelton
2. Date of Death Month/Day/Year: October 31, 2001
3. Time of Death: 23:53 P M
4a. Facility Name (If not institution, give street and number): Mercy Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City

Funeral Director

5. Social Security Number: 577-44-6079
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03 18 34
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 1114 Guilford Ave
10f. Zip Code: 21202
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waiter
16b. Kind of Business/Industry: Prime Rib Restaurant

17. Father's Name (First, Middle, Last): Herbert Shelton
18. Mother's Name (First, Middle, Maiden Surname): Gladys Unknown

19a. Informant's Name/Relationship (Type, Print): Carl J. Barnwell II-Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1114 Guilford Ave, Baltimore, Md 21202

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 11/3/01
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Jerry R. Thompson Jr
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Gram positive bacteremia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death: 24hours

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease
Diabetes
Acute Renal Failure

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: Karen A. Kozicki, MD
29c. License number: D40744
29d. Date signed (Month, Day, Year): October 31, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.A. Kozicki Mercy Hospital 301 St. Paul Pl, Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: Jessica D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35189

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bernhard Edward Staub
2. Date of Death: Month Oct, Day 31, Year 2001
3. Time of Death: 5:20 AM
4a. Facility Name (If not institution, give street and number): 2207 Smith Avenue
4b. City, Town, or Location of Death: Lansdowne
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-24-7644
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Aug. 7, 1929
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Lansdowne
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2207 Smith Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 4-15-51 to 1-19-53
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Joseph Staub
18. Mother's Name (First, Middle, Maiden Surname): Theresa Besser

19a. Informant's Name/Relationship (Type, Print): Edward B. Staub Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2207 Smith Avenue, Lansdowne, MD 21227

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.
Date: 11-1-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature] 10/25/01
22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, MD 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CONGESTIVE HEART FAILURE — 6 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: 036336
29d. Date signed (Month, Day, Year): November 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick Kunn MD 3449 Willkens Ave # 300

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RR

RR 4

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35190

Amend Item 25 PER PHY G801 11/05/01 RR

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
MARGARET	SHEEHAN, S.N.D.	OCTOBER 24, 2001	3:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SAINT JOSEPH MEDICAL CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-56-9921	1☐ M 2☒ F	85 Yrs.			Nov. 17, 1915	MA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Owings Mills	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
6-A Regalia Ct.	21117	USA

11. Meritel Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12	5+	Teacher	Elementary Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Patrick Sheehan	Catherine Corcoran

19a. Informent's Neme/Reletionship (Type, Print)	19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Sisters of Notre Dame de Namur	1531 Greenspring Valley Rd. Stevenson, MD 21153

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Sisters of Notre Dame	10/27/01	Ilchester, MD

21. Signeture of Funeral Service Licensee	22. Name and Address of Feclity
	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediete Cause (Final diseese or condition resulting in death)	a. ACUTE TYPE A AORTIC DISSECTION	7 DAYS
	Due to (or as e consequence of):	
Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

HYPERTENSION

23b. Did tobacco uas contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one)

Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner es stated.

2☐ **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and menner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D38655	10/24/01

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

R.C. STEWART FINNEY, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signature
NOV 05 2001	

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35191

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH STABLER

2. Date of Death: Month 10 Day 30 Year 2001

3. Time of Death: 4:15 AM

4e. Facility Name (If not institution, give street and number): St. Joseph Nursing Home

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-10-1626

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 23 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1222 Tugwell Drive

10f. Zip Code: 21228

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Chemical

17. Father's Name (First, Middle, Last): Alvin Thomas Jones

18. Mother's Neme (First, Middle, Maiden Surneme): Helen Graves

19a. Informent's Neme/Relationship (Type, Print): Edmund T. Stabler / son

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): #7 Palow Court, Arbutus, Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other placa): Stablersville UMC Cem. Date: 11/1/01

20c. Location - City or Town, State: Parkton, Maryland

21. Signature of Funeral Service Licensee: ▶ Heather A. Brown

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deelh. Do not enter the mode ot dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Parkinson's Disease. — 5y

Due to (or es a consequence ot):

b. Organic Brain Syndrome — 1y.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequenca of):

c. Aspiration Pneumonia

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatienl 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, date end placa, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steled.

29b. Signeture end title of certifier: ▶ Alejandro Mejia MD

29c. License number: D0008780

29d. Date signed (Month, Dey, Year): 10/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALEJANDRO MEJIA MD 405 Frederick Rd Baltimore 21228

State Registrar

31. Date filed (Month, Day, Year): NOV 0 5 2001

32. Registrer's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35192

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen R. Sechrist
2. Date of Death Month Day Year: November 1, 2001
3. Time of Death: 9:10pm
4a. Facility Name *(If not institution, give street and number)*: Carroll Lutheran Village
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 210-14-0872
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 22, 1916
9. Birthplace *(State or Foreign Country)*: Pittsburgh PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 250 St. Luke Circle
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: George L. Rapp
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary V. Kaufman

19a. Informant's Name/Relationship *(Type, Print)*: Leslie Ann Ratliff - daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8 Churchberry Ct. Reisterstown, MD 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowbranch Cemetery | Date: 11/5/01
20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee: Jeff B Eline
22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Rd, Reisterstown, MD 21136

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Aspiration Pneumonia — 1 day

Due to (or as a consequence of):
b. Stroke — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation
Type 2 Diabetes Mellitus
Hypertension
Alzheimers Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Daniel Alexander
29c. License number: D52815
29d. Date signed *(Month, Day, Year)*: 11/2/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Daniel Alexander 686 Poole Road Westminster, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 0 5 2001
32. Registrar's Signature: Teresa G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH t6 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35193

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSE MARIE SWANTKO
2. Date of Death (Month, Day, Year): OCTOBER 31, 2001
3. Time of Death: 11:35 A M
4e. Facility Name (If not institution, give street and number): NORTH WEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-50-5699
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 17, 1947
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 22 W. Chestnut Hill Lane
10f. Zip Code: 21136
10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Bookkeeping

17. Father's Name (First, Middle, Last): Corbit Arrowood
18. Mother's Name (First, Middle, Maiden Surname): Ethel Hansen

19a. Informant's Name/Relationship (Type, Print): Maximilian M. Swantko /Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 W Chestnut Hill Lane Reisterstown, MD 21136

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fern Knoll Burial Park
Date: 11/1/01
20c. Location - City or Town, State: Dallas, PA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION — 1 DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D57722
29d. Date signed (Month, Day, Year): OCTOBER 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LEONARD RICHARDSON MD 5401 OLD COURT ROAD, RANDALLSTOWN MD 21133

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: [signature] Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

01-6151-510
crn
Mary V. Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35194

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY VIOLA SMITH
2. Date of Death Month Day Year: October 31, 2001
3. Time of Death: 7:10 A M
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-30-5332
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 25, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 4 North Ashburton Street
10f. Zip Code: 21223
10g. Citizen of Whel Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Engineer
16b. Kind of Business/Industry: Self

17. Fether's Name (First, Middle, Last): Louis Queen
18. Mother's Name (First, Middle, Maiden Surname): Mary Palmer

19a. Informant's Name/Relationship (Type, Print): Wilbert Smith- Husband
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 North Ashburton St. Baltimore, MD 21223

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison For. Vet. Date: 11/07/01
20c. Location - City or Town, State: OwingsMills, MD

21. Signature of Funeral Service Licensee: Michael Zigler
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Data of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

Inspection

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Stephen Radentz, M.D.
29c. Licanse number: O.C.M.E.
29d. Date signed (Month, Day, Year): October 31, 2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 0 5 2001
32. Registrar's Signature: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that tha death certificate be axecuted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35195

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Rebekah A. Schmick	October 30, 2001	10:15 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
32 Far Corners Loop	Sparks	Baltimore

Funeral Director

5. Social Security Number	8. Sex 1☐M 2☐F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-18-6787	X	92			3-26-1909	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Sparks	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
32 Far Corners Loop	21152	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed X 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Moore	Anna Gladhill

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs Denise A. Wagner (Daughter)	32 Far Corners Loop, Sparks, Maryland 21152

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	11-2-01	Towson, Maryland 21204

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wallace S. Brooks, Jr.	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GI Bleed	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): chronic diarrhea	years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

abdomenal surgeries and adhesions, dementia

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Helen M. Gordon	D0051926	November 2, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Helen M. Gordon MD 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 5 2001	▶ D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#26 PER PHY G801 11/05/01 JH

Certificate of Death

Reg. No. 2001 35196

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Hyland Price Stewart, 3rd	October 27, 2001	4:42 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1813 Maryland Ave.	Phoenix	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-18-4684	1 [X] M 2 [ ] F	80 Yrs.			7-20-1921	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Towson	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
403 Central Ave.	21204	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Publisher	Stewart Directories

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Sumeme)
Hyland Price Stewart, Jr.	Alice Baldwin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Mr. Paul F. Burch (Step Son)	616 Highland Ave., Towson, Maryland 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Hilltop Service Corp.	10-29-01	Towson, Maryland

21. Signeture of Funerel Service Licensee	22. Name and Address of Facility
▶ Wallace S. Brooks, Jr.	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 2120

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediete Cause (Final disease or condition resulting in death)	a. congestive heart failure	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as e consequence of):	
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

foot ulcer
diabetes

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown	
24e. Was en eutopsy performed? 1 [ ] Yes 2 [X] No	24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No	26. Place of Deeth (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [X] Other (Specify) DAUGHTERS RESIDENCE

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Alan Kimmel MD	D25783	10-29-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alan Kimmel MD 6769 N. Charles St Balt Md 21204

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
NOV 05 2001	▶ Bernice D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar	3. Tima of Daath
Ruth Pearson Bosland Suhrie	November 2, 2001	4 pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Deeth
10358 York Road, Apt. 119	Cockeysville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Data of Birth (Month, Day, Yaer)	9. Birthplace (Stata or Foraign Country)
152-10-3366	1☐M 2☒F	85 Yrs.			Jun 30, 1916	NJ

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Cockeysville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
10358 York Road, Apt. 119	21030	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Giva Year or Dates:	1☐Yas 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Florist	Horticulture

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Pearson	Theresa Fugman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Fay Bosland /Daughter	3 Kirwin Court, Balitmore, MD 21234

20a. Method of Disposition	20b. Place of Disposition (Nama of cematary, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1☐Burial 2☒Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)	Chesapeake Crematory	Nov 6 2001	Beltsville, MD

21. Signature of Funeral Service Licensee	22. Nama and Addrass of Facility
	Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar the moda of dying, such es cardiac or respiratory errast, shock, or heart failure. List only ona causa on each lina.

		Approximate Intarval Batwaan Onset and Daath
Immediate Cause (Final disease or condition resulting in death)	a. METASTIC Colon CANCER	2yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	2 years
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequance of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pregnancy	23d. Data of delivary Month Day Yaar
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

SLOW GASTRO INTESTINAL BLEED.

23e. Did tobacco usa contributa to tha causa of daath?	24a. Was an autopsy performed?	24b. Were autopsy findings availabla prior to completion of causa of daath?
1☐Yas 2☒No 3☐Probably 4☐Unknown	1☐Yas 2☒No	1☐Yas 2☐No

25. Was case referred to medical examiner?	28. Place of Daath (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Othar: 4☐Nursing Homa 5☒Rasidance 6☐Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined		M	1☐Yes 2☐No	

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)	28f. Location (Straet and Numbar or Rural Routa Numbar, City or Town, Stata)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowladga, death occurrad at the tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, deta and place, and due to tha causa(s) and manner stated.

29b. Signatura and title of cartifier	29c. Licansa numbar	29d. Data signad (Month, Day, Yaar)
M.D.	D07182	11/3/01

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

RICHARD MAFFEZZOLI 515 FAIRMOUNT AVE. BALT, MD 21286

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
NOV 05 2001	D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
LAWRENCE TATE
01-6159-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35198

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
LAWRENCE	V.	TATE	OCTOBER 31, 2001	1542 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BAYVIEW HOSPITAL	BALTIMORE CITY	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214 38 9344	1 [X] M 2 [ ] F	60 Yrs.			OCT. 18, 1941	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	EDGEMERE	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2509 SYCAMORE AVE.	21219	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		DISABLED	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES W. TATE	FRANCES GALIMORE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CAROLYN DEWS/SISTER	1229 KITMORE RD BALTO., MD 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	MT. ZION	11/6/01	BALTO., MD

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC
1701 LAURENS ST., BALTO., MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	OCME	NOVEMBER 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JONATHAN LEE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	Brenda B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

RKD

01-5677-003

SYLVIA

VACCHIO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 022602: ITEMS #23a, 27 per ME G804 ss

Certificate of Death

Reg. No. 2001 35199

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month Day Year	3. Time of Death
Sylvia	Vacchio	OCTOBER 5, 2001	12:54P.M.

4a. Facility Name (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
3510 OLD ANNAPOLIS ROAD	LAUREL	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Yaar: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
UNK	1☐ M 2☒ F	51 Yrs.			Jan. 18, 1950	Washington, DC

Usual Raisdance of Decedent

10a. Sieta	10b. County	10c. City, Town or Locaiion	10d. Insida City Limits
MD	Prince George's	Laurel	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
9210 A Traders Crossing	20723	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.)	14. Raca - American Indian, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Giva Year or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Business/Industry
Elamentery/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own home

17. Fathar's Nama (First, Middla, Last)		18. Mothar's Nama (First, Middla, Maiden Surnema)	
Pasquale	Vacchio	Alberta	Littleford

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Eric J. Vacchio/Brother	4621 Roxbury Drive, Bethesda, MD 20814

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cemetary, crematory or othar piece)	Data	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cramelion 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)	Chesapeake Crematory	Oct. 26, 2001	Beltsville, MD

21. Signature of Funeral Service Licensee	22. Nema and Addrass of Facility
▶ [signature]	Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that causad tha daath. Do not antar tha mode of dying, such es cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach line.

Approximete Interval Between Onsat and Deth

Immediate Cause (Final disaase or condition resulting in death)

e. ATHERSCLEROTIC CARDIOVASCULAR DISEASE

Dua to (or as a consaquance of):

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last

b.

Dua to (or as a consequance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to dealh but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contributs to the causs of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of daath?
1☑ Yas 2☐ No	1☐ Yes 2☐ No

25. Was case rafarred lo medical examiner?	26. Piece of Death (Check only ona)	
1☒ Yas 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Othar: 4☐ Nursing Homa 5☐ Rasidance 6☒ Othar (Specify) SCENE

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☑ Pending investigation 6☐ Could not be datarmined		M	1☐ Yes 2☐ No	

28a. Piece of Injury - At homa, farm, straat, fectory, office building, atc. (Spacify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29e. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledga, death occurred at tha tima, data and place, end dua to tha causa(s) and menner es steted.

2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, deeth occurred et tha tima, data end plece, and due to the cause(s) end mennar steted.

29b. Signatura and title of certifiar	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	OCTOBER 6, 2001

30. Nema and address of person who complaled cause of death (Item 23a) (Type, Print)

MARGARITA A. KORELIS, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
NOV 05 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2058.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35200

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara Joan Williams
2. Date of Death Month Day Year: Oct 30 2001
3. Time of Daath: 9:30 PM
4a. Facility Name (If not institution, give street and number): 700 West Bel Air Ave #328
4b. City, Town, or Location of Death: Aberdeen
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-40-1669
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 7 1924
9. Birthplace (State or Foreign Country): England

Usual Residence of Decedent

10a. State: Md
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 700 West Bel Air Ave #328
10f. Zip Code: 21001
10g. Citizen of What Country? USA

11. Marital Status: 1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): shoe department
16b. Kind of Businass/Industry: Hecht's Dep. Store

17. Father's Name (First, Middle, Last): Roger Clark
18. Mother's Nama (First, Middle, Maidan Surnama): unknown

19a. Informant's Name/Relationship (Type, Print): Paul Williams SON
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1672 Dr. Jack Rd. P.O. Box 387 Conowingo, Md 21918

20a. Mathod of Disposition: 1☐Burial 2☒Cramation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Placa of Disposition (Nama of cemetary, crematory or other placa): Evans Funeral Chapel Bel Air
Date: Oct 31 2001
20c. Location - City or Town, State: Forest Hill Md
21. Signature of Funeral Service Licensee: Krista L Wells
22. Name and Address of Facility: Evans Funeral Chapel 3 Newport DR Forest Hill, Md 21050

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one causa on aach line.

Approximata Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death):
a. ACUTE MYOCARDIAL INFARCTION — 1 DAY

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disaase or injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
b. ISCHEMIC HEART DISEASE
Due to (or as a consequance of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedant pregnant in the past 12 months? 1☐Yas 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were eulopsy findings availabla prior to compiation of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Placa of Daath (Check only ona): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)
27. Manner of Daath: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar (Check only one): 1☒Certifying Physician: To the bast of my knowledga, death occurrad at the tima, date and place, and dua to tha cause(s) and mennar as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, date and place, and due to tha causa(s) and manner stated.
29b. Signature and title of certifier: Andrew Nowakowski MD
29c. License number: D0 80 9 6
29d. Date signed (Month, Dey, Year): OCTOBER 31, 2001

30. Name and address of parson who completed cause of daath (Item 23a) (Typa, Print): DR. Andrew Nowakowski 125 N. Main St. Bel Air, Md

State Registrar

31. Date filed (Month, Day, Year): NOV 0 5 2001
32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

RR

RR 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Edward Wells	11	02	01	1641 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland	Baltimore	Baltimore

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-90-3739	1 X M 2 ☐ F	39 Yrs.			09-02-1962	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
424 Folcroft Street	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	X Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	1yr	Stock Clerk	Retail

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Edward Wells	Brenda Elizabeth Walker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jacqueline E. Wells (Wife)	424 Folcroft St. Baltimore, MD. 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Arbutus Mem Park	11/07/01	Arbutus, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Dennis B. Caple	Dennis B. Caple Fun'l Home 5502 Winner Ave. Baltimore, MD. 21215

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End stage renal disease

Due to (or as a consequence of):

b. Hypertension.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypoxic brain injury.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No	1 ☐ Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
P. Sean Van Sill	AU4176435U13171	11/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Sean Van Sill 22 S. Greene St. Baltimore MD. 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	Deputy G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: AMEND ITEM #5 PER FAX 0801 11/05/01 JH

Certificate of Death

Reg. No. 2001 35202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DARRYLL C. WRIGHT

2. Date of Death (Month, Day, Year): November 01 2001

3. Time of Death: 905 PM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-66-6458 UNKNOWN

6. Sex: 1 ☐ M 2 ☒ F

7. Age (If yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 26, 1954

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Hanover

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 145 Chesapeake Mobile Court

10f. Zip Code: 21076

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Admimistrative Spec. II

16b. Kind of Business/Industry: Mass Transit Administration

17. Father's Name (First, Middle, Last): Curtis Lester Wright

18. Mother's Name (First, Middle, Maiden Surname): Namoi Grafton

19a. Informant's Name/Relationship (Type, Print): Dorothy Wright - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 145 Chesapeake Mobile Ct. Hanover, MD21076

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 11/07/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Michael Zegleer

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Balto. MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b. Multi organ failure — Days.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnency 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cadaver Renal transplant Recipient
Diabetes Mellitus type II
Asthma

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician

29c. License number: H0057773

29d. Date signed (Month, Day, Year): 11/02/01

30. Name and address of person who completed cause of death (Item 23a) (Type / Print): Jose M. Pestana, DO 300 Hospital Drive Suite 215 Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001

32. Registrar's Signature: Barbara D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wright, Darryll

A

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Ilona Marie Wilkinson	October 31 2001	0945 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-07-9360	1☐M 2☒F	84 Yrs.			may 13, 1917	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
411 North Poplar Hill Avenue	21802	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Home Maker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
John Murray	Helen Lencz

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John P. Wilkinson, III/Son	17 Stillway Garth Cockeysville, Md.21030

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Slete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Olivet Cemetery	11/8/01	Chattanooga, Tenn.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediete Cause (Final disease or condition resulting in deeth)	a. Pneumonia	10 days
	Due to (or as a consequenca of):	
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b. Chronic Renal Failure	10 years
	Due to (or as e consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alveolar Edge

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Menner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1☐Yes 2☐No	

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner staled.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	H00507 43	11/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Branton, MD 1201 Pemberton Dr. Salisbury MD 21801

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ILONA Wilkinson 221-07-9360

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 5 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #30 PERDVR G801 11/05/01 JH

Certificate of Death

Reg. No. 2001 35204

CHARLES WILHELM NOVEMBER 3, 2001
Baltimore, Maryland 21215-0020 063444

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES FRANK WILHELM, JR

2. Date of Death (Month, Day, Year): November 3, 2001

3. Time of Death: 6:34 AM

4a. Facility Name (If not institution, give street and number): Hospice of Baltimore, Gilchrist Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-16-1533

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 8, 1917

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 52 Greenmeadow Dr.

10f. Zip Code: 21093

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: WW-II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronic Technician

16b. Kind of Business/Industry: Radio & Television

17. Father's Name (First, Middle, Last): Charles Frank Wilhelm, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Belle Klages

19a. Informant's Name/Relationship (Type, Print): Mrs. Earscell G. Wilhelm/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 52 Greenmeadow Dr. Timonium, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial

Date: 11/6/01

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CHF — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. atherosclerotic heart disease — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D0051926

29d. Date signed (Month, Day, Year): November 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HELEN MINIFIE GORDON HOSPICE OF BALTIMORE, GILCHRIST CENTER

State Registrar

31. Date filed (Month, Day, Year): NOV 0 5 2001

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35205

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leroy O. Walters
2. Date of Death (Month, Day, Year): November 1, 2001
3. Time of Death: 2:30 A.M.
4a. Facility Name (If not institution, give street and number): 4414 St. Thomas Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-20-4574
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 27, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4414 St. Thomas Ave
10f. Zip Code: 21206
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: Glenn L. Martin

17. Father's Name (First, Middle, Last): John Walters
18. Mother's Name (First, Middle, Maiden Surname): Margaret Beckleheimer

19a. Informant's Name/Relationship (Type, Print): Merle Wood / nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4414 St. Thomas Ave., Baltimore, MD 21206

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 11/5/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Colon Adenocarcinoma — 29 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D15450
29d. Date signed (Month, Day, Year): NOV 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mohamed S. Al-Ibrahim 10 N. Greene St. Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 05 2001
32. Registrar's Signature: Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35206

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nancy A. Yarrow

2. Date of Death Month Day Year: NOVEMBER 2, 2001

3. Time of Death: 6:50 AM

4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-03-7366

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN. 21, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14 Derwood Ct.

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White.

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dispatcher

16b. Kind of Business/Industry: Elevator Company

17. Father's Name *(First, Middle, Last)*: Harry Akehurst

18. Mother's Name *(First, Middle, Maiden Surname)*: Anne P. Nichols.

19a. Informant's Name/Relationship *(Type, Print)*: Patricia B. Viergens-friend

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14 Derwood Ct. Parkville MD 21234.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crest Lawn Cemetery

Date: 11-05-01

20c. Location - City or Town, State: Marriottsville, MD.

21. Signature of Funeral Service Licensee: Kristal J. Wells

22. Name and Address of Facility: Evans Funeral Home 8800 Harford Rd. Parkville MD 21234

Nancy A. Yarrow

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Abdominal Wall Abscess — 8 days

Due to (or as a consequence of):

b. Bladder Cancer — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

Entero cutaneous Fistula

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 057444

29d. Date signed *(Month, Day, Year)*: NOV. 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alexander Chen, M.D.

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 05 2001

32. Registrar's Signature: Bonnie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Re Yarrow

RF 6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 35207

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lyverne Teresa Young

2. Data of Death Month Day Yaer: November 2, 2001

3. Time of Death: 3:50 pm

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center for Hospice Care

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-60-5727

6. Sex: 1☐M 2☒F

7. Aga *(In yrs. last birthday)*: 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Year)*: Oct 1, 1951

9. Birthplece *(State or Foreign Country)*: MD

Usuel Residence of Decedent

10a. Stata: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1528 Gleneagle Road

10f. Zip Code: 21239

10g. Citizen of What Country?: United States

11. Marital Stetus: 1☐ Never Married 2☒Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grada completed)*: Elementery/Secondery (0-12): ; College (1-4or 5+): 2

16e. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: Medical Records Clerk

16b. Kind of Business/Industry: Health Care

17. Father's Neme *(First, Middle, Last)*: Robert Finney

18. Mother's Name *(First, Middle, Maiden Surneme)*: Isis Tutman

19e. Informent's Name/Relationship *(Type, Print)*: Jonathan Young /Husband

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1528 Gleneagle Road, Baltimore, MD 21239

20e. Method of Disposition: 1☒Burial 2☐Cramation 3☐Ramovel from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Oaklawn Cemetery

Date: Nov 7 2001

20c. Location - City or Town, State: Balitmore, MD

21. Signature of Funaral Service Licensee: [signature]

22. Name end Address of Fecility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in death)

e. Breast cancer — years

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last

b. —

Due to (or as a consequence of):

c. —

Dua to (or as a consequanca of):

d. —

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to compiation of causa of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Plece of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* Hospice

27. Manner of Death: 1☒Naturel 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2☐**Medical Examiner:** On the basis of examination end/or invastigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and mannar steted.

29b. Signeture and title of certifier: [signature]

29c. License number: D0051926

29d. Date signed *(Month, Dey, Year)*: November 3, 2001

30. Name and address of person who completed cause of daeth (Item 23a) (Type, Print): Helen M Gordon MD 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Lyverne Young, November 2, 2001 @ 3:50pm

#15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35208

Elizabeth D. Andrew
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner — To Be Completed by Funeral Director

Funeral Director — To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Andrew					2. Date of Death (Month, Day, Year): October 22, 2001	3. Time of Death: 1910 M	
4a. Facility Name (If not institution, give street and number): Memorial Hospital		4b. City, Town, or Location of Death: Easton			4c. County of Death: Talbot		
5. Social Security Number: 215-62-1394	6. Sex: 1☐M 2☒F	7. Age (In yrs. last birthday): 95 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): September 30, 1906	9. Birthplace (State or Foreign Country): Maryland	
Usual Residence of Decedent							
10a. State: Maryland	10b. County: Talbot	10c. City, Town or Location: Easton				10d. Inside City Limits: 1☐Yes 2☒No	
10e. Street and Number: 501 Dutchmen's Lane		10f. Zip Code: 21601			10g. Citizen of What Country?: United States		
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasian		
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 HS Grad. / College (1-4or 5+): 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker			16b. Kind of Business/Industry: Home		
17. Father's Name (First, Middle, Last): William T. Dukes					18. Mother's Name (First, Middle, Maiden Surname): Lulu Bonwill		
19a. Informant's Name/Relationship (Type, Print): Ormond L. Andrew, Jr. Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2181 Jamieson Avenue #1503, Alexandria, VA 22314					
20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donation 5☐Other (Specify)	20b. Piece of Disposition (Name of cemetery, crematory or other place): Denton Cemetery	Date: 10/25/01	20c. Location - City or Town, Stete: Denton, Maryland				
21. Signature of Funeral Service Licensee: ▶ [signature]		22. Name and Address of Facility: Moore Funeral Home, P.A. 12 South Second Street, Denton, MD 21629					

Physician /Medical Examiner — Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)
a. Bilateral Pneumonia — 2 days
Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as e consequenca of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetat deeth 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Atrial fibrillation

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] | 29c. License number: D0053602 | 29d. Date signed (Month, Day, Year): 10/23/01

30. Name and address of person who completed cause of death (Item 28a) (Type, Print): Carolyn Helmly, M.D., 606 Dutchmen's Lane, Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year): OCT 24 2001

32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35209

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE ELIZABETH RYE BOWIE
2. Date of Death (Month, Dey, Yeer): OCT. 23, 2001
3. Time of Death: 1:30 AM
4a. Facility Name (If not institution, give street end number): STELLA MARIS HOSPICE
4b. City, Town, or Location of Deeth: TIMONIUM
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-46-3362
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): SEPT. 28, 1911
9. Birthplace (State or Foreign Country): MARYLAND

Usuel Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: NANJEMOY
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11705 MARYLAND POINT ROAD
10f. Zip Code: 20662
10g. Citizen of Whet Country?: U.S.A.

11. Merital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 7 — College (1-4or 5+): -----
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Neme (First, Middle, Last): HOWARD WILLIS RYE
18. Mother's Name (First, Middle, Maiden Surneme): EVA ELOISE KENDRICK

19a. Informent's Name/Relationship (Type, Print): DERYL M. BOWIE- SON
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3123 FALLSTON AVENUE, BELTSVILLE, MD 20705

20a. Method of Disposition: ☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): NANJEMOY CHURCH CEMETERY — Date: OCT. 26, 2001
20c. Location - City or Town, State: NANJEMOY, MD

21. Signature of Funeral Service Licensee: JOHN P. KNISLEY
22. Neme and Address of Facility: HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MD 20604-0156

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth): a. CEREBROVASCULAR ACCIDENT
Due to (or es a consequence of):
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last: b. ____ Due to (or as a consequence of): c. ____ Due to (or es e consequence of): d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causs of death? 1☐ Yss 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicat exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as steted. 2☐ **Medicat Examiner:** On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature end title of certifier:
29c. License number: D43725
29d. Date signed (Month, Dey, Yeer): 10/23/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 25 2001
32. Registrar's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

OCTOBER 23, 2001 1:30 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

FLORENCE BOWIE

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35210

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Georgia Carol Barnes
2. Data of Death: Month October Day 16 Year 2001
3. Time of Death: 12:12AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-90-9645
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 36 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): July 3, 1965
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 13729 Unionville Rd.
10f. Zip Code: 21771
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus driver
16b. Kind of Business/Industry: Private Contractor

17. Father's Name (First, Middle, Last): Albert Zimmerman
18. Mother's Name (First, Middle, Maiden Surname): Grace Zecher

19a. Informant's Name/Reletionship (Type, Print): Robert W. Barnes/husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13729 Unionville Rd. Mt. Airy, Md. 21771

20e. Method of Disposition: 1☐ Burial 2☒ Crametion 3☐ Ramovel from State 4☐ Donation 5☐ Other (Specify)
20b. Place ot Disposition (Name of cemetery, crematory or other place): All County Cremation
Date: 10/18/01
20c. Location - City or Town, State: Sykesville, Md.

21. Signature of Funeral Sarvice Licensee: Catharine O. Hartzler
22. Name and Address of Facility: Hartzler Funeral Home, 11802 Liberty Rd. Libertytown, Md. 21762

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the daath. Do not enter tha mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia — 1 mo
Due to (or as a consequence ot):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last:
b. lung Cancer — 1½ yrs
Dua to (or as a consequenca ot):
c.
Dua to (or as a consequenca ot):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No
26. Place ot Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner ot Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date ot Injury (Month, Day Year)
28b. Time ot Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place ot Injury - At home, ferm, street, tactory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Gene Ashe MD
29c. License number: D0031054
29d. Date signed (Month, Day, Year): 10/17/01

30. Neme and address ot person who completed cause ot death (Item 23a) (Type, Print): Gene F. Ashe, M.D. 10200 Coppermine Rd., P.O. Box 6, Woodsboro, MD 21798

State Registrar

31. Dete tiled (Month, Day, Year): OCT 19 2001
32. Registrar's Signature: Jerome B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that tha death certificata be executed within 24 hours after death.
To the Funeral Director: After this certificata has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

WJR 9

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35211

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRY FRED BRANDT

2. Date of Death (Month, Day, Year): OCTOBER 19, 2001

3. Time of Death: 1905

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 482-16-3554

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT. 11, 1919

9. Birthplace *(State or Foreign Country)*: IOWA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1514 RIVERSIDE DR. APT. 323B

10f. Zip Code: 21801

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: POSTAL CARRIER

16b. Kind of Business/Industry: U.S. POSTAL SERVICE

17. Father's Name *(First, Middle, Last)*: CHARLES BRANDT

18. Mother's Name *(First, Middle, Maiden Surname)*: MATILDA KLUSS

19a. Informant's Name/Relationship *(Type, Print)*: DENISE B. BUCHLY - stepdaughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 422 VALLEYWOOD DR. SALISBURY, MD 21804

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CREMATORY OF DELMARVA

Date: 10-24-01

20c. Location - City or Town, State: DELMAR, DELAWARE

21. Signature of Funeral Service Licensee: B. Kurtz CFSP

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Guillian Barré syndrome.
cervical spinal cord compression

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rodney A. Wenrich, M.D.

29c. License number: D15384

29d. Date signed *(Month, Day, Year)*: 10/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RODNEY A. WENRICH 100 POWER ST. SALISBURY MD 21804

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 22 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

BRANDT, HARRY 482-16-3554 10-18-01 1905 84y

9+/VA DQ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35212

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALLIE MAE BROTHERTON
2. Date of Death: Month 10 Day 25 Year 2001
3. Time of Death: 10:50a M
4a. Facility Name (If not institution, give street and number): Aahtul Assisted Living
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 249-05-7715
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 98 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08 04 1903
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 8518 Wind Dance Way
10f. Zip Code: 21045
10g. Citizen of Whel Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Licensed Practical Nurse
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Hughey Andrew Bledsoe
18. Mother's Nema (First, Middle, Maiden Surname): Flora Robinette

19a. Informant's Name/Relationship (Type, Print): daughter Beatrice Bernice Brotherton
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 802 Key Court #211 Laurel, MD 20707

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Ft. Lincoln Cemetery
Date: 10/29/01
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: M)1213
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave., Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION, AORTIC STENOSIS, CEREBROVASCULAR ACCIDENT

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and menner as steted. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D24035
29d. Date signed (Month, Day, Yeer): 10/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ESMALHAD 321 PRINCE GEORGE STREET Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): OCT 26 2001
32. Registrar's Signature: Donna G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(8)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Doris Louise Blankenship	October 25, 2001	5:30 pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
228 Spring Gap S.	Laurel	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-14-8315	1☐M 2☒F	81 Yrs.			11/14/1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Savage	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8335 Woodward Street	20763	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown		Babysitter	Day Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
(unknown) Pierce	Bertha Wines

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Louise Wheeler/ daughter	228 Spring Gap S. Laurel, MD 20724

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify)	Savage Cemetery	10/29/01	Savage, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] MO1213	Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Biliary Tract Carcinoma
Cardiomyopathy

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	27. Manner of Death
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) daughter's home	1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
☒☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William A Warren MD	D13916	October 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William A. Warren, MD 321 Price George St. Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 31 2001	▶ Bernice D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

1-1 fax

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 35214

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry W. Bergholz, Sr.

2. Date of Death (Month, Day, Year): October 21, 2001

3. Time of Death: 1700

4a. Facility Name (If not institution, give street and number): 216 Main Street

4b. City, Town, or Location of Death: Marydel

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 140-26-5077

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul. 13, 1934

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Caroline

10c. City, Town or Location: Marydel

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10a. Street and Number: 216 Main Street

10f. Zip Code: 21649

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates: 1957

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver/Lumberjack

16b. Kind of Business/Industry: Trucking/Timber

17. Father's Name (First, Middle, Last): Fred Bergholz

18. Mother's Name (First, Middle, Maiden Surname): Rose Aikley

19a. Informant's Name/Relationship (Type, Print): Dennis Bergholz, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17985 Marvel Rd., Marydel, MD 21649

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Eglington Cemetery

Date: 10/26/01

20c. Location - City or Town, State: Clarksboro, NJ

21. Signature of Funeral Service Licensee: ▶ Michael F. Eskow

22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. L leg gangrene — Approximate Interval: 2 mo.

Due to (or as a consequence of):

b. Diabetes Mellitus — Approximate Interval: 10y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I.

Acute Renal Failure
Congestive Heart Failure

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D35284

29d. Date signed (Month, Day, Year): 10/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREA ALLEN MD 295 Washington St. Easton MD 21601

State Registrar

31. Date filed (Month, Day, Year): OCT 2 2 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35215

Mary Brown

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Salmons Brown
2. Data of Death Month Day Year: Oct. 22, 2001
3. Time of Death: 6:25 am
4a. Facility Name *(If not institution, give street and number)*: Dulaney Nursing Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 222-30-8536
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 7-14-1918
9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. State: Delaware
10b. County: Kent
10c. City, Town or Location: Dover
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 150 Saulsbury Road
10f. Zip Code: 19904
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: James Salmons
18. Mother's Name *(First, Middle, Maiden Surname)*: Esther Gibson

19a. Informant's Name/Relationship *(Type, Print)*: Nicholas S.Brown - son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2482 Smith Mill Rd.,New Freedom,PA 17349

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Christ Epis.ChurchCem. Date: Oct.25 2001
20c. Location - City or Town, State: Dover, Delaware

21. Signature of Funeral Service Licensee: John A. Prince
22. Name and Address of Facility: Pippin Funeral Home 19934, 119 W. Camden-Wyoming Ave, Wyoming,DE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Parkinson Disease — 5yrs

Due to (or as a consequence of): b. Dementia — 5yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending Physician
29c. License number: D53642
29d. Date signed *(Month, Day, Year)*: October 22 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K/DOLHOW 3007 E Northern Parkway Baltimore 21214

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 24 20[illegible]
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35216

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arthur Alvin Clark

2. Date of Death (Month, Day, Year): October 22 2001

3. Time of Death: 4:55 AM

4a. Facility Name *(If not institution, give street and number)*: Dulaney Towson Manor Care

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-30-3149

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 1, 1929

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1051 Roland Heights Avenue

10f. Zip Code: 21211

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1951-1959

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puerto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Fork Lift Operator

16b. Kind of Business/Industry: Warehouse Work

17. Father's Name *(First, Middle, Last)*: Arthur F. Clark

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Loretta Saylor

19a. Informant's Name/Relationship *(Type, Print)*: Lillian Santymyer (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5106 Richard Avenue, Baltimore, Maryland 21214

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park

Date: 10/24/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Carol Blumberg

22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

To Be Completed by Funeral Director

Clark, Arthur A.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident — 2 months

Due to (or as a consequence of):

b. Coronary Artery Disease — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Attending Physician

29c. License number: D53662

29d. Date signed *(Month, Day, Year)*: October 22 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kirk Olson 3007 E Northern Parkway Baltimore 21214

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

2

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 23 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35217

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Uldino Caputi

2. Date of Death Month: October Day: 28 Year: 2001

3. Time of Death: 4:50 PM

4a. Facility Name *(If not institution, give street and number)*: Manor Care Nursing Home

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 023-28-0307

6. Sex: 1 ☐ M 2 ☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 21, 1913

9. Birthplace *(State or Foreign Country)*: Italy

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8809 Church Field Lane

10f. Zip Code: 20708

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5th grade | College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tailor

16b. Kind of Business/Industry: Garment

17. Father's Name *(First, Middle, Last)*: Ambrogio Caputi

18. Mother's Name *(First, Middle, Maiden Surname)*: Natalina Caranfa

19a. Informant's Name/Relationship *(Type, Print)*: Rossetta Maria Agres / daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8809 Church Field Lane Laurel, Maryland 20708

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ivy Hill Cemetery | Date: Nov. 2, 2001

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature] / M00770

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Sepsis — Days

Due to (or as a consequence of):
b. Pneumonia — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
c. Urinary Tract Infection — Days

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D43260

29d. Date signed *(Month, Day, Year)*: October 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jenny Moy 13952 Baltimore Ave Laurel MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 31 2001

32. Registrar's Signature: ▶ [signature] Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RJD
IMARI CONWAY
01-6096-047

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 022502: ITEMS #23a, 27, 28a-f per ME 6804 ss

Certificate of Death

Reg. No. 2001 35218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Imari M. Conaway	OCTOBER 27, 2001	1610P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
517 BAY STREET APT. A9	BERLIN	WORCESTER

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-53-3245	1☒M 2☐F	3 Yrs.			June 27, 1998	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Worcester	Berlin	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
517 Bay St., Apt. A9	21811	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
n/a		n/a	n/a

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Dontae Dale	Nicole I. Conaway

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nicole I. Conaway/mother	517 Bay St., Apt. A9, Berlin, MD 21811

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	St. Paul's Cemetery	11/03/2001	Berlin, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SMOKE INHALATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Wes cese referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) (SCENE)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☒Could not be determined	10-27-01	3:40p M	1☐Yes 2☒No	Victim of house fire

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
residence	517 Bay Street, Berlin, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. M. T.	O.C.M.E.	OCTOBER 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
JACK McTIGHE, M.D.	111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

RJD

01-6095-047

JAKAI CONWAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 022502: ITEMS #23a, 27, 28a-f per ME 6804 ss

Certificate of Death

Reg. No. 2001 35219

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jakai M. Conaway

2. Data of Death Month Day Year: OCTOBER 27, 2001

3. Time of Death: 1608 P. M

4a. Facility Name *(If not institution, giva street and number)*: 517 BAY STREET APT A9

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER CO.

Funeral Director

5. Social Security Number: 218-55-6565

6. Sex: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 2 Yrs.

If Undar 1 Year: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yaar)*: Aug 29, 1999

9. Birthplaca *(Stata or Foreign Country)*: MD

To Be Completed by Funeral Director

Usual Rasidence of Decedent

10a. Stata: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Insida City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 517 Bay St., Apt.A9

10f. Zip Code: 21811

10g. Citizan of What Country?: U.S.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☐ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grade compiatad)*: Elementary/Secondary (0-12): n/a; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT usa ratirad)*: n/a

16b. Kind of Businass/Industry: n/a

17. Father's Name *(First, Middle, Last)*: Terrez M. Rounds

18. Mother's Nama *(First, Middle, Maiden Surname)*: Nicole I. Conaway

19a. Informant's Name/Ralationship *(Type, Print)*: Nicole I. Conaway/mother

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 517 Bay St., Apt. A9, Berlin, MD 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematery, crematory or othar place)*: St. Paul's Cemetery

Data: 11/3/2001

20c. Location - City or Town, Stata: Berlin, MD

21. Signature of Funaral Service Licensee ▶

22. Nama and Address of Facility: Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications that caused the daath. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each lina.

Approximate Intarval Batween Onsat and Daath

Immediate Cause (Finel disease or condition resulting in death): a. SMOKE INHALATION

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disaasa or injury that initiated events resulting in daath) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnent in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yas, outcoma of pregnancy 1☐ Liva birth 2☐ Fatal daath 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Othar *(specify)* 9☐ Unknown

23d. Dete of dalivery Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause givan in Part I.

23e. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Ware autopsy findings availabla prior to compiation of causa of death? 1☒ Yas 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case refarred to medical axaminer? 1☒ Yas 2☐ No

26. Place of Daath *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☒ Othar *(Specify)* (SCENE)

27. Mannar of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be datarmined

28a. Date of Injury *(Month, Day Yaar)*: 10-27-01

28b. Tima of Injury: 3:40p M

28c. Injury at Work? 1☐ Yas 2☒ No

28d. Describe how injury occurrad: Victim of house fire

28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*: residence

28f. Locetion *(Straat and Number or Rural Routa Numbar, City or Town, Stata)*: 517 Bay Street, Berlin, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To tha bast of my knowledga, death occurrad at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to the ceusa(s) and mannar stated.

29b. Signatura and titla of certifiar ▶ J. M. T.

29c. Licensa number: O.C.M.E.

29d. Data signed *(Month, Day, Yaar)*: OCTOBER 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 05 2001

32. Registrar's Signature ▶ Geneva G Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 35220

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOMINIC JOSEPH COLANDREA

2. Date of Death Month: 10 Day: 19 Year: 01

3. Time of Death: 2350 PM

4a. Facility Name *(If not institution, give street and number)*: CALVERT MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: PRINCE FREDERICK, MD.

4c. County of Death: CALVERT

Funeral Director

5. Social Security Number: 047 16 2071

8. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 23 1923

9. Birthplace *(State or Foreign Country)*: Italy

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Lusby

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12555 Tongue Cove Lane

10f. Zip Code: 20657

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5 +

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Real Estate

17. Father's Name *(First, Middle, Last)*: Raphaele Colandrea

18. Mother's Name *(First, Middle, Maiden Surname)*: Maria Gracia Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Patricia S. Colandrea- wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12555 Tongue Cove Lane Lusby MD 20657

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Funeral Service — Date: Oct. 20 2001

20c. Location - City or Town, State: Alexandria Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. rd. Port Republic MD 2067

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL VASCULAR ACCIDENT — Approximate Interval Between Onset and Death: 10 DAYS

Due to (or as a consequence of):

b. HYPERTENSION — 20 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: H0037228MD

29d. Date signed *(Month, Day, Year)*: 10/20/01 4:40 PM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR STEPHEN P. CAFFERTY 1350 DARES BEACH RD PRINCE FREDERICK MD 20678

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 22 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10+ 19 rallis

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35221

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Sigrid Christa Chubb

2. Dete of Death Month Dey Year: Oct. 17, 2001

3. Time of Death: 8:45 am

4e Facility Neme *(If not institution, give street end number)*: 10603 Waco Drive

4b. City, Town, or Location of Deeth: Upper Marlboro

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 262-68-2024

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 61 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: 4/13/1940

9. Birthplece *(State or Foreign Country)*: Germany

Usuel Residence of Decedent

10e. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: ☒Yes 2☐No

10e. Street end Number: 10603 Waco Drive

10f. Zip Code: 20772

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Merried 2☐ Merried 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indien, Blecк, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Budget Analyst

16b. Kind of Business/Industry: County Government

17. Father's Neme *(First, Middle, Last)*: Aurtur Walter Pinske

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Marianna Wilhelmine Wiegand

19a. Informent's Neme/Reletionship *(Type, Print)*: Christopher Chubb/Son

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3141 Hale Ct., Huntingtown, MD 20639

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crem.

Date: 10/18/01

20c. Location - City or Town, Stete: Alexandria, VA

21. Signature of Funerel Service Licensee: E. Wood

22. Neme end Address of Fecility: Raymond-Wood F.H., P.A. P.O. Box 430, Dunkirk, MD 20754

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Adenocarcinoma of lung — 3 months

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:

b. Metastasis to Brain — 3 months

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Erica Isles MD.

29c. License number: D0054000

29d. Date signed *(Month, Dey, Yeer)*: October 17, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): ERICA ISLES MD, 6409 South Crain Highway, Upper Marlboro, MD 20772

10

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 18 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35222

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virgie (nmn) Duty

2. Date of Death Month Dey Yeer: October 20, 2001

3. Time of Death: 12:11 PM

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-24-0444

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Jan. 11, 1912

9. Birthplece (Stete or Foreign Country): West Virginia

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 2211 Old Mountain Road Central

10f. Zip Code: 21085

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondery (0-12): 3

College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Melvin (nmn) Roberts

18. Mother's Neme (First, Middle, Meiden Surneme): Victoria (nmn) Bailey

19a. Informent's Neme/Reletionship (Type, Print): Halsey L. Duty / Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2211 Old Mountain Rd. Central, Joppa, MD 21085

20a. Method of Disposition: 1☒Buriel 2☐Cremation 3☐Removel from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Bel Air Memorial Grdns. Dete: 10-24-01

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stanley A. Keech

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

Immediate Ceuse (Finel disease or condition resulting in death): a. Myocardial Infarction

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as e consequence of):

d.

Approximate Interval Between Onset and Death: 7days

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown

23d. Dete of delivery Month Dey Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end manner as steted. 2☐Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: William P. Cook

29c. License number: D41596

29d. Date signed (Month, Dey, Yeer): October 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Cook 1131 Bel Air Rd Bel Air MD 21014

State Registrar

31. Date filed (Month, Dey, Yeer): OCT 23 2001

32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Duty, Virgie

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35223

DAISEY, EMMA

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6
DQ

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Emma Jane Daisey	Oct. 19 2001	1325 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
230-01-7110	1☐M 2☒F	92 Yrs.			Sept. 13, 1909	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Va.	Accomack	Chincoteague	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3498 Ridge Rd.	23336	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7	—	Homemaker	Self

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edgar Fish	Madge Thornton Fish

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Herbert Lee Daisey Son	6269 Highland Park Rd. Chincoteague Va 23336

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Greenwood Cemetery	10-23-2001	Chincoteague Va.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Constance Salyer Cook Bailey	Salyer Funeral Home, 6327 Church ST, Chincoteague Va

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonitis	6 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

leukemia - chronic myelocytic
atrial fibrillation

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Rodney A. Wenrich, M.D.	D15384	10/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RODNEY A. WENRICH, M.D. 100 POWER ST. SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 22 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35224

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Nettie Mae Dennis	October	14	2001	1641 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-28-1823	1☐M 2☒F	70 Yrs.			Mar.25,1931	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Dorchester	Rhodesdale	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Post Office Box 83	21659	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yas 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Norman Jones	Bertha Coleman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carolyn L. Jones/Daughter	PO Box 271, Vienna, MD 21869

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Reids Grove Cem.	10/20/01	Reids Grove, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael F. Eskow	Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Organ System Failure — 2-3 Days

Due to (or as a consequence of):
b. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Suspected INFARCted Bowel

Due to (or as a consequence of):
d.

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yas 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Other (specify) 9☐Unknown

23d. Date of delivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to tha cause of death? 1☐Yas 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to compiation of cause of death? 1☐Yas 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only ona)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Othar: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signad (Month, Dey, Year)
▶ MD	039813	10/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
M ATKINS 1104 Wesley Mary Drive Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 2001	▶ D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

214-28-1823
Nettie Dennis
Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35225

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph D. Fitzgerald, Jr.

2. Date of Death: Month October Day 17 Year 2001

3. Time of Death: 9:21 P M

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-12-9633

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 7, 1926

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1034 Circle Drive

10f. Zip Code: 21784

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Advertising

17. Father's Name (First, Middle, Last): Ralph D. Fitzgerald, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Lillian Patterson

19a. Informant's Name/Relationship (Type, Print): Mr. Barry J. Fitzgerald (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1034 Circle Drive Sykesville, MD 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Cem.

Date: 10/24/01

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Brian D. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequenca of):

d. Due to (or as e consequence of):

IF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Dey Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Acute myocardial Infarction

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: K. Ambalavanar

29c. Licanse number: D51596

29d. Dete signed (Month, Day, Yeer): October 17th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. Ambalavanar Carroll County General Hospital, 200 Memorial Ave, Westminster, MD 21157.

State Registrar

31. Date filed (Month, Day, Yeer): OCT 19 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJZ 3+1 VA

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35226

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Yaar	3. Tima of Death
Shirley Joyce Gorman	Oct. 18 2001	4:05 aM

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Daath	4c. County of Death
725 Uniontown Road	Westminster	Carroll

Funeral Director

5. Social Sacurity Numbar	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yaar)	9. Birthplace (Stete or Foreign Country)
292-14-1801	1☐M 2☒F	78 Yrs.			May 15 1923	Ohio

Usual Residence of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	Carroll	Westminster	1☐Yes 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizen of Whet Country?
725 Uniontown Road	21158	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas? If Yas, Giva Yaar or Detes:	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. Rece - Amarican Indian, Black, Whita, atc.
1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced	☒Yas 2☐No WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedant's Education (Specify only highest grade completed)		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Businass/Industry
Elemantary/Secondary (0-12)	College (1-4or 5+)		
	2	Medical Records/Supervisor	University Hospital

17. Fathar's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Hugh Moses	Peggy White

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
Joseph M. Gorman/husband	725 Uniontown Road Westminster, MD 21158

20a. Mathod of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Data	20c. Location - City or Town, Stata
1☒Burial 2☐Cremation 3☐Ramoval from Stata 4☐Donation 5☐Other (Specify)	Liberty Church Cem	10/20/2001	Westminster, MD

21. Signatura of Funaral Servica Licensee ▶ [signature]

22. Name and Address of Facility
Pritts Funeral Home and Chapel
412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the daath. Do not entar the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on aach lina.

Approximate Interval Between Onsat and Daath

Immediate Cause (Finel disaasa or condition rasulting in daath)
a. COPD — Dua to (or as a consequence of): — 20 yrs

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaasa or injury that initiated avents resulting in daath) Last
b. CAD — Due to (or as a consequence of): — 10 yr
c. — Dua to (or as a consequance of):
d.

IF FEMALE: 23b. Was decedent pregnant in tha past 12 months?	23c. If yes, outcome of pregnancy	23d. Data of dalivary Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fatel daath 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Othar (specify) 9☐Unknown	

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23a. Did tobecco use contributa to tha causa of daath? 1☒Yas 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐Yas 2☒No	1☐Yas 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case raferred to madical axaminer? 1☐Yas 2☒No

28. Place of Daath (Check only one)
Hospital: 1☐Inpatiant 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Homa 5☒Rasidence 8☐Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yaer)	28b. Time of Injury M	28c. Injury at Work?	28d. Dascribe how injury occurrad
1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding investigation 6☐Could not be datarmined			1☐Yes 2☐No	

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one) 1☒ **Certifying Physician:** To the bast of my knowledga, daath occurrad at the tima, data end place, and dua to tha cause(s) and mannar as stated.
2☐ **Medical Examinar:** On tha basis of axaminetion and/or investigation, in my opinion, daath occurrad at tha tima, data and place, and due to tha causa(s) and mannar stated.

29b. Signatura and title of cartifier	29c. License number	29d. Data signed (Month, Day, Yaar)
▶ John W. Middleton MD	D25443	10/18/01

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)
John W. Middleton 688 Poole Road, Westminster Md 21157

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signatura
OCT 22 2001	▶ [signature]

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJR 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35227

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marguerite H. Gordon

2. Date of Death Month Oct. Day 29, Year 2001

3. Time of Death: 7:30P M

4a. Facility Name (If not institution, give street and number): Holy Cross Rehab. & Nursing Home

4b. City, Town, or Location of Death: Burtonsville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 095 12 6955

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 27, 1922

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Clarksville

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 7392 Minter Lane

10f. Zip Code: 21029

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Secretary

16b. Kind of Business/Industry: Assistant Dist. Attny.

17. Father's Name (First, Middle, Last): William Hoops

18. Mother's Name (First, Middle, Maiden Surname): Caroline Hecht

19a. Informant's Name/Relationship (Type, Print): Caryl G. Fitzgibbon/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7392 Minter Lane Clarksville, Maryland 21029

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Luth. Cem.

Date: 11/02/2001

20c. Location - City or Town, State: Columbia, Maryland

21. Signature of Funeral Service Licensee: [signature] M01142

22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Uterine Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fatal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maria Goldmark, MD

29c. License number: D25346

29d. Date signed (Month, Day, Year): 10/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Maria Goldmark 11906 Darnstown Road North Potomac, Maryland 20878

State Registrar

31. Date filed (Month, Day, Year): OCT 31 2001

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35228

Shirley Gelletly

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Shirley Anne Gelletly					2. Date of Death: Month October Day 24 Year 2001			3. Time of Death: 1029 M
4a. Facility Name (If not institution, give street and number): The Memorial Hospital			4b. City, Town, or Location of Death: Easton			4c. County of Death: Talbot		
5. Social Security Number: 357-20-4001	6. Sex: 1☐M 2☒F	7. Age (In yrs. last birthday): 74 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): February 9, 1927		9. Birthplace (State or Foreign Country): Illinois	

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Caroline	Denton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24838 Pealiquor Road	21629	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detas:	1☐Yes 2☒No Specify:	Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12	6	Teacher	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Sumame)
Wilson Edwin Mundhenke	Anne Louise Voeks

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kenneth Gelletly Husband	24838 Pealiquor Road, Denton, Maryland 21629

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stata
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Denton Cemetery	10/27/2001	Denton, Maryland

21. Signature of Funeral Service Licensee: Randolph Moore

22. Name and Address of Facility: Moore Funeral Home, P. A. 12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	a. hypoxemia	2 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	b. Due to (or as a consequence of): sepsis	2 days
	c. Due to (or as a consequence of): urinary tract infection	2 days
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐Yas 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accidant 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Karen Moffett M.D.	D51639	10-25-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Karen Moffett, M.D., PO Box 660, Denton, Maryland 21629

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 26 2001	G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35229

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Fred Carven Galemore
2. Date of Death Month Day Year: Oct. 20, 2001
3. Time of Death: 2:00 am.
4a. Facility Name *(If not institution, give street and number)*: 4311 Landing Lane
4b. City, Town, or Location of Death: Dunkirk
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 422-18-2389
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9-9-1923
9. Birthplace *(State or Foreign Country)*: Alabama

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert
10c. City, Town or Location: Dunkirk
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4311 Landing Lane
10f. Zip Code: 20754
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician
16b. Kind of Business/Industry: GSA

17. Father's Name *(First, Middle, Last)*: Joseph Wheeler Galemore
18. Mother's Name *(First, Middle, Maiden Surname)*: Belle Thompson

19a. Informant's Name/Relationship *(Type, Print)*: Mary C. Galemore/Spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4311 Landing Lane, Dunkirk, MD 20754

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: S. Memorial Gardens
Date: 10/24/01
20c. Location - City or Town, State: Dunkirk, MD

21. Signature of Funeral Service Licensee: C. Ward
22. Name and Address of Facility: Raymond-Wood F. H., P.A. PO Box 430, Dunkirk, MD 20754

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Respiratory Failure
Due to (or as a consequence of):
b. Cor Pulmonale
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D33123
29d. Date signed *(Month, Day, Year)*: 10-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Johnathan Lowenthal, 10945 Town Center Blvd., Dunkirk, MD 20754

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 22 2001
32. Registrar's Signature: Bernice G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35230

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Essie Mae Goodman
2. Date of Death (Month, Day, Year): Oct. 9, 2001
3. Time of Death: 6:32p. M
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 254 16 5679
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Nov. 26, 1909
9. Birthplace (State or Foreign Country): Ga.

Usual Residence of Decedent

10a. State: MD.
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 13119 Cabin Wood Drive
10f. Zip Code: 20904
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8yrs; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laundry Cleaner
16b. Kind of Business/Industry: Pvt.

17. Father's Name (First, Middle, Last): Stephen McCray
18. Mother's Name (First, Middle, Maiden Surname): Charity Lee

19a. Informant's Name/Relationship (Type, Print): Jannie B. Emery / Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5544 4th Street,N.E. Washington, D.C. 20011

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Eastside Cemetery
Date: 10/20/2001
20c. Location - City or Town, State: Statesboro, Ga.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: John T. Rhines Co. 3030 12th. St.,N.E. Wash.,D.C. 20017

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): Necrotizing Fasciitis — Approximate Interval Between Onset and Death: one week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia Septicemia

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No
28. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Martin C Shargel MD
29c. License number: D08944
29d. Date signed (Month, Day, Year): 10/10/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Martin C. Shargel, M.D. 3720 Farragut Ave. Kensington M.D. 20895 - 2110

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

CF

Pg 23A

(2)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35231

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mabel Hylton Hope

2. Date of Death (Month, Day, Year): October 23, 2001

3. Time of Death: 1:30 A. M

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-22-6692

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 7, 1918

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: White Marsh

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5661 Gunpowder Road

10f. Zip Code: 21162

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): George W. Hylton

18. Mother's Name (First, Middle, Maiden Surname): Laura Jane Cantrell

19a. Informant's Name/Relationship (Type, Print): Mr. David Hope (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 47 Longeron Drive, Baltimore, MD 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.

Date: 10/25/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mabel T. Hope

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

To Be Completed by Funeral Director

Hope, Mabel
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction — 45 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Sunil Ahuja MD

29c. License number: D28762

29d. Date signed (Month, Day, Year): 10-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Sunil Ahuja, 9000 Franklin Square Drive, Baltimore, Maryland 21237

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

dm

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State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001

32. Registrar's Signature: ▶ Denise D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35232

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Katherine Hays

2. Date of Death Month: Oct Day: 18 Year: 2001

3. Time of Death: 4:30 a.m.

4a. Facility Name *(If not institution, give street and number)*: Carroll Lutheran Village

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 202-32-3179

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 13, 1909

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 310 St. Luke Circle

10f. Zip Code: 21158

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 11 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Neme *(First, Middle, Last)*: Truman Eugene Lambert

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Ann Flickinger

19a. Informent's Neme/Reletionship *(Type, Print)*: Granville H. Hibberd/ nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3314 Mill Dale Lane New Windsor, MD 21776

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Emmitsburg Memorial Cem. Date: 10/22/01

20c. Location - City or Town, Stete: Emmitsburg, MD

21. Signature of Funerel Service Licensee: Catharine Q. Hartzler

22. Name and Address of Feciility: Hartzler Funeral Home 310 Church St. New Windsor, MD 21776

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in deeth) a. Aspiration Pneumonia — 3 days

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End Stage Mixed Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signeture end title of certifier:

29c. License number: M37444

29d. Date signed *(Month, Day, Year)*: Oct. 18th 2001.

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Alexander Bandarchuk 245 Stemer Ave, Westminster MD 21157

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 22 2001

32. Registrar's Signature:

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Katherine L Hays

WJ 15

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35233

Robert T. Hearn 222 07 8854

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
ROBERT	THOMAS	HEARN	10 / 21 / 2001	0143 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
222-07-8854	1☒M 2☐F	85 Yrs.			MAY 24, 1916	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
30367 DAGSBORO RD	21804	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		ENGINEERING MECHANIC	PUMP MANUFACTURER

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Sumeme)
BENJAMIN REE HEARNE	MAUDE THOMAS RAYNE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LAVINA S. HEARN - WIFE	30367 DASBORO RD SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	DENNIS CEMETERY	10-26-01	WILLARDS, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nelson Ray Bounds	705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month / Dey / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

Urinary Tract Infection

Anemia

Chronic Obstructive Pulmonary Disease

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Dey, Year)
▶ [signature] MD	H0057410	10/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Simona Eng 100 E. Carroll St. Salisbury MD 21801

30 DQ

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 23 2001	▶ Penina G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Marcus Handy
CJ
01-6093-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 112801:ITEMS#23a,27,28a-f per ME 6601 ss

Certificate of Death

Reg. No. 2001 35234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARCUS ANTONIO HANDY
2. Date of Death: Month October Day 27 Year 2001
3. Time of Death: 07:00 P.M
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-21-5075
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 13 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-30-88
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 536-WINDER ST.
10f. Zip Code: 21801
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STUDENT
16b. Kind of Business/Industry: BENNETT MID. SCH.

17. Father's Name (First, Middle, Last): ROBERT DORSEY HANDY SR.
18. Mother's Name (First, Middle, Maiden Surname): HOPE DENISE HANDY

19a. Informant's Name/Relationship (Type, Print): HOPE D. HANDY ~ MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 420-DELAWARE AVE, SALISBURY, MD. 21801

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): GREEN ACRES
Date: 11/5/01
20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SMOKE INHALATION AND THERMAL INJURIES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 10-26-01
28b. Time of Injury: 11:52p M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Victim of house fire
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 536 Winder St., Salisbury, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J M. T
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): October 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 01 2001
32. Registrar's Signature: Denise G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35235

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Eugene L. Hooper	October 26, 2001	6:55 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Howard County General Hospital	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-16-4161	1☒M 2☐F	79 Yrs.			Oct. 7, 1922	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
920 Imperial Court	21227	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Letter Carrier	U.S. Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Eugene L. Hooper, Sr.	Catherine McCarthy

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Edna Hooper/Wife	920 Imperial Court Baltimore, MD 21227

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removet from State 4☐Donation 5☐Other (Specify)	Louden Park Cem.	10/30/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature] 100142	Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	1mo
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☒Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D31322	10/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRADEEP GARG MD 716 MAIDEN CHOICE LANE, BALTO MD 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 29 2001	[signature] P Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(8)

CGJ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35236

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JOHN HASLUP	10 - 28 - 01	9-45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LAUREL REGIONAL HOSPITAL	LAUREL	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-42-8324	1 [X] M 2 [ ] F	56 Yrs.			12-14-44	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Fulton	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8282 Murphy Road	20759	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1961-66	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Surveyor	Utility Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Baldwin Haslup	Emily Houser

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judy R. Haslup /spouse	8282 Murphy Road, Fulton, Maryland 20759

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Mt. Zion Cemetery	11/01/2001	Highland, Maryland

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
[signature]	M00773	Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SMALL CELL CANCER OF THE LUNG

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. WITH METASTASIS TO THE LIVER — 3-WEEKS

Due to (or as a consequence of):

c. AND BONE MARROW AND MEDIASTINUM

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION WITH RAPID VENTRICULAR RESPONSE.
CORONARY ARTERY DISEASE.
DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] Abdul Nayeem MD	D.21294	10-28-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL NAYEEM, M.D.
3450 FORT MEADE ROAD SUITE 100, LAUREL, M.D. 20724

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 31 2001	[signature] G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35237

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lucille Mary Hooper

2. Date of Death Month Day Year: Oct 17, 2001

3. Time of Death: 535 PM

4a. Facility Name *(If not institution, give street and number)*: Calvert County Nursing Center

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 214 58 1981

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 23 1919

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Prince Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1270 Adelina Road

10f. Zip Code: 20678

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: meat wrapper/ meat dept.

16b. Kind of Business/Industry: A & P Food Store

17. Father's Name *(First, Middle, Last)*: Harry Wood

18. Mother's Name *(First, Middle, Meiden Surname)*: Catherine McKay

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Rawlings- daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1126 Prince Frederick, MD 20678

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Central Cemetery Oct

Date: 22 2001

20c. Location - City or Town, State: Prince Frederick Maryla

21. Signature of Funeral Service Licensee: ▶ DRausch

22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Cerebrovascular accident — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnency 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent et time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

atorial fibzillation, HTN, Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Zahir Yousaf MD.

29c. License number: D0027189

29d. Date signed *(Month, Day, Year)*: 10.18.2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zahir Yousaf, MD Huntingtown MD 20639

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001

32. Registrar's Signature: ▶ Renee G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 35238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ida Mae Jeffries	October 25, 2001	1:30 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Cherry Lane Nursing Center	Laurel	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-14-4997	1☐ M 2☒ F	91 Yrs.			10/5/1910	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George	Laurel	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9001 Cherry Lane	20708	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Dan Starling	Della Hager

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marvin F. Jeffries/ Son	107 Hitch Pond Circle Seaford, Delaware 19973

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Bryant Cemetery	10/29/01	Paint Bank, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M)1213	Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, MD 20707

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Coronary Artery Disease	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined			1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M.D.	D24721	10/26/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Sadiq 14333 Laurel Bowie Rd. Suite 208 Laurel, MD 20708

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 26 2001	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

cgf

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35239

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Kirkpatrick

2. Data of Death — Month: October Day: 27, Yaar: 2001

3. Tima of Daath: 8:38 AM

4a. Facility Name (If not institution, give street and number): Family Care Assisted Living

4b. City, Town, or Location of Daath: Marriottsville

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 493-03-2161

6. Sex: XX M 2 F

7. Aga (In yrs. last birthday): 88 Yrs.

If Undar 1 Year — Months: Days: If Undar 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Yaar): Sept. 21, 1913

9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Howard

10c. City, Town or Location: Marriottsville

10d. Inside City Limits: 1 Yas 2 X No

10e. Street and Number: 12105 Old Frederick Road

10f. Zip Coda:

10g. Citizen of What Country?: United States

11. Marital Status: 1 Never Married 2 Married XX Widowed 4 Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 X Yas 2 No If Yes, Give Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 Yas 2 X No Specify:

14. Race - Amaricen Indian, Black, Whita, atc. Specify: white

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired): Claims Adjuster

18b. Kind of Businass/Industry: Social Security

17. Father's Nama (First, Middle, Last): Luther Harmon Kirkpatrick

18. Mother's Name (First, Middla, Maiden Sumame): Lula Windsor

19a. Informant's Name/Relationship (Type, Print): Terry Kirkpatrick/Son

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 5536 Hunting Horn Drive Ellicott City, MD 21043

20a. Method of Disposition: 1 Buriat 2 X Cremation 3 Removal from Stata 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cematary, cramatory or othar place): Metro Crematory

Data: 10/29/2001

20c. Location - City or Town, Stata: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Andre Amato M00845

22. Nama and Addrass of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only ona cause on each lina.

Approximate Intarval Batwean Onsat and Daath

Immediate Cause (Final disease or condition resulting in death)

a. Asthenia — Due to (or as a consequence of): — Yes

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DIABETES — Due to (or as a consequence of): — Yes

c. Dementia — Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yas, outcoma of pregnancy 1 Live birth 2 Fatal death 3 Ectopic pregnancy 4 Pregnant at tima of daath 5 Other (specify) 9 Unknown

23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23a. Did tobacco usa contributa to tha causa of daath? 1 Yas 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yas 2 No

24b. Wara autopsy findings availabla prior to completion of ceusa of daath? 1 Yas 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

28. Placa of Daath (Check only ona)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Othar: 4 Nursing Homa 5 X Rasidance 6 Othar (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1 Yas 2 No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 **Certifying Physician:** To tha best of my knowledge, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar as stated. 2 **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: HAO

29c. Licensa number: D31172

29d. Data signad (Month, Day, Yaar): October 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H.A. Oke MD 3460 Ellicott Center Dr 103 Ellicott City MD 21043

State Registrar

31. Data filed (Month, Day, Year): OCT 29 2001

32. Registrar's Signatura: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: Aftar this cartificate has been signed by the attending physician and completely filled in by the funaral director, paga 2 should be datached for use as tha burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35240

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Ann Lee

2. Date of Death — Month: OCTOBER Day: 23, Year: 2001

3. Time of Death: 1:00 AM

4a. Facility Name *(If not Institution, give street and number)*: LORIEN @ RIVERSIDE

4b. City, Town, or Location of Death: BELCAMP

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 217-01-1617

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 11, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1114 Mountain Road

10f. Zip Code: 21085

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Alexander (unk) Wentworth

18. Mother's Name *(First, Middle, Maiden Surname)*: Wilmina (unk) (unk)

19a. Informant's Name/Relationship *(Type, Print)*: Carol A. Day-Meadows/ Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1114 Mountain Road, Joppa, MD 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery — Date: 10-26-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Stephen A. Meeds

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. Cerebrovascular accident — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 8☐ Could not be determined

28a. Dete of fnjury *(Month, Day Year)*

28b. Time of fnjury M

28c. fnjury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, In my opinion, deeth occurred et the time, date and plece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: [signature]

29c. License number: D28339

29d. Date signed *(Month, Day, Year)*: October 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LINDA FRENCH 601 E Lobel Road Edgemoor

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 23 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

HELEN A LEE

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35241

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Janine Marie Lyons
2. Date of Death Month Day Year: October 19, 2001
3. Time of Death: 1200 M
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215 64 4782
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 45 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 15, 1956
9. Birthplace *(State or Foreign Country)*: Wash., DC

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Harwood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4281 Sands Road
10f. Zip Code: 20776
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: teacher, guidance counselor
16b. Kind of Business/Industry: public schools
17. Father's Name *(First, Middle, Last)*: Paul Edward Newman
18. Mother's Name *(First, Middle, Maiden Surname)*: Otilia Angela Smith
19a. Informant's Name/Relationship *(Type, Print)*: James I. Lyons (husb.)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as 10af above
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Mt. Zion UM Church
Data: 10-23-01
20c. Location - City or Town, State: Lothian, MD
21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC BREAST CANCER — Approximate Interval: 20 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier ▶ Peter Rapp MD
29c. License number: D16364
29d. Date signed *(Month, Day, Year)*: 10/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PETER R RAPP MD 900 BESTGATE RD 300 ANNAPOLIS MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 24 2001
32. Registrar's Signature ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35242

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): May Lucinda Mohr

2. Date of Death Month Day Year: October 18 2001

3. Time of Death: 8:00 PM

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-10-2395

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 23, 1915

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md.

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 983 Top View Drive

10f. Zip Code: 21040

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8 years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): salesperson

16b. Kind of Business/Industry: retail

17. Father's Name (First, Middle, Last): William Lyles

18. Mother's Name (First, Middle, Maiden Surname): Clara Penn

19a. Informant's Name/Relationship (Type, Print): Leona "Lee" M. Schmidt/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8611 Wendell Avenue, Baltimore, Md. 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Lutheran Cem.

Date: 10/22/2001

20c. Location - City or Town, State: Joppa, Md.

21. Signature of Funeral Service Licensee: ▶ Christina L. David

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory FAILURE — 6 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE — 72 hours

Due to (or as a consequence of):

c. Metastatic adenocarcinoma of colon — 10 days

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D47463

29d. Date signed (Month, Day, Year): October 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott A. Steinmetz MD 520 Upper Chesapeake Drive Bel Air Md 21014

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001

32. Registrar's Signature: Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

May Lucinda Mohr

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35243

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Fern A Mack
2. Date of Death: Month Oct. Day 17 Year 01
3. Time of Death: 2:20pm
4a. Facility Name (If not institution, give street and number): COPPER RIDGE
4b. City, Town, or Location of Death: SYKESVILLE
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 139-54-8340
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUL 29 1915
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: TN
10b. County: Loudon
10c. City, Town or Location: Loudon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 123 Oostanali Way
10f. Zip Code: 37774
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic
17. Father's Name (First, Middle, Last): Harry M. Ritter
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Young
19a. Informant's Name/Relationship (Type, Print): Judith M. Bailey (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 123 Oostanali Way, Loudon TN 37774
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Northhampton Mem. Shrine
Date: 10/20/01
20c. Location - City or Town, State: Palmer Twp., PA
21. Signature of Funeral Service Licensee: Harry W. Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville MD 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's Dementia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ernestine Wright, MD
29c. License number: D52740
29d. Date signed (Month, Day, Year): October 17th 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ernestine Wright, 516 North Rolling Road, Suite 204, Catonsville MARYLAND 21228

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

WJZ 5

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001
32. Registrar's Signature: Jenna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar 11/1/01amend#4cgf

Certificate of Death

Reg. No. 2001 35244

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry C. MacKay

2. Date of Death: Month Oct. Day 29, Year 2001

3. Time of Death: 10:15 A M

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: ~~219-10-1937~~ ~~239-27-3071~~

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): May 13, 1926

9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3004 North Ridge Road

10f. Zip Code: 21043

10g. Citizen of Whet Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 4

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Engineer

16b. Kind of Business/Industry: Whitman, ReGueard Asso

17. Father's Name (First, Middle, Last): John MacKay

18. Mother's Nome (First, Middle, Meiden Sumame): Eva Beckett

19e. Informent's Neme/Relationship (Type, Print): Gloria MacKay/Wife

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 3004 North Ridge Road Ellicott City, MD 21043

20e. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Metro Crematory

Dete: 10/30/2001

20c. Location - City or Town, Stete: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Charlie Smith M00845

22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Myocardial Infarction — Due to (or as e consequence of): — Approximate Interval: 1 hour

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnency 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Dete of delivery: Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes cese referred to medical exeminer? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end menner stated.

29b. Signature and title of certifier: Patrick White MD

29c. License number: D0023365

29d. Dete signed (Month, Dey, Yeer): 10/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrick W. White M.D. 405 Frederick Rd, #202, Baltimore, MD

State Registrar

31. Date filed (Month, Dey, Yeer): OCT 31 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35245

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
IVY JACOBS MIRON	October 18 2001	4:30 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert Memorial Hospital	Prince Frederick	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578 50 6524	1☐M 2☑F	84 Yrs.			July 12, 1917	England

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Calvert	Dunkirk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3715 Ferry Landing Road	20754	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry Herbert Hackshaw	Jessie Beatrice Radford

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janis Gavai, daughter	same as # 10 a-f above

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Trinity Mem. Gardens	10-20-2001	Waldorf, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ William K. Gross	Rausch Funeral Home, P.A., Owings, MD 20754

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Acute Osteomyelitis	
	Due to (or as a consequence of):	
	c. C. diff colitis	
	Due to (or as a consequence of):	
	d. Rheumatoid arthritis	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D 50290	10-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dhiren Shah, M.D. Prince Frederick, MD 20678

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	▶ Jenna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35246

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Katherine Dolores Munson

2. Date of Death Month: October Day: 16 Year: 2001

3. Time of Death: 3:00 a M

4a. Facility Name *(If not institution, give street and number)*: 5506 Calvert Street

4b. City, Town, or Location of Death: Churchton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-40-7113

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 27, 1931

9. Birthplace *(State or Foreign Country)*: Wash., D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Churchton

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 5506 Calvert Street

10f. Zip Code: 20733

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

18b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Wilbur S Finch

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie S Schwartz

19a. Informant's Name/Relationship *(Type, Print)*: George J. Munson, Sr., spouse

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: same as # 10 a-f above

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: MD Veterans Cemetery

Dete: 10-22-2001

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: ▶ William R. Gross

22. Name end Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ovarian cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. bowel obstruction

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: 29142

29d. Date signed *(Month, Day, Yeer)*: 10-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES BOICE, M.D. ANNAPOLIS, MD

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 18 2001

32. Registrar's Signature ▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

CPM
01-6106-510
WALTER MALONEY, JR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED111901:ITEMS 23a,27,28a-f per Mr. Gall ss

Certificate of Death

Reg. No. 2001 35247

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Walter H. Maloney, Jr.	OCTOBER 28, 2001	19:36 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHOCK TRAUMA	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-40-8917	1 [X] M 2 [ ] F	71 Yrs.			Oct. 22, 1930	Missouri

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Beltsville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whel Country?
4305 Josephine Avenue	20705	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, Whita, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1954-1962	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5+	Attorney	U.S. Government

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter H. Maloney, Sr.	Madeline Farley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cecelia F. Maloney - wife	4305 Josephine Avenue Beltsville, Maryland 20705

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Gate of Heaven Cemetery	11/3/2001	Silver Spring, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald V. Borgwardt	Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MULTIPLE INJURIES COMPLICATING HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings availabla prior to complation of causa of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Wes casa refarred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yas 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [X] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined	10-28-01	4:37p M	1 [ ] Yes 2 [X] No	Driver in auto/fixed object impact

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Numbar, City or Town, State)
Road	Benfield & Old Benfield Rds., Severna Park, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner es stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	OCTOBER 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. LAWTON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signature
NOV 0 5 2001	▶ Geneva B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35248

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
MARGO	JOYCE	NOLAN	October 19, 2001	1410 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-42-8298	1☐M 2☒F	85 Yrs.			DEC. 13, 1915	NEW JERSEY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	WICOMICO	SALISBURY	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1011 HEALTHWAY DRIVE	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5±	JOURNALIST	NEWSPAPER

17. Father's Name (First, Middle, Last)		18. Mother's Neme (First, Middle, Meiden Surname)	
LEO	JOYCE	MARGARET	KENNEDY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
MICHAEL NOLAN - SON	1300 FREDERICK AVENUE SALISBURY, MD 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CREMATORY OF DELMARVA	10/20/2001	DELMAR, DE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
William Ray Henry	BOUNDS FUNERAL HOME 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Cardiomyopathy	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Coronary Arteryo Disease	years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Wes decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
	D36783	10/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Fitherton, MD PRMC SALISBURY MD 21804

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
OCT 22 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Margo Nolan

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10 DQ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35249

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Fred Thomas Proffitt
2. Date of Death: Month 10 Day 20 Year 01
3. Time of Death: 1800 M
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 238-30-5769
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 12, 1925
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Cecil
10c. City, Town or Location: Perryville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 634 Otsego Street
10f. Zip Code: 21903
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder
18b. Kind of Business/Industry: Pipe Manufacturing

17. Father's Name (First, Middle, Last): William Henry Proffitt
18. Mother's Name (First, Middle, Maiden Surname): Emma Thomas

19a. Informant's Name/Relationship (Type, Print): Mrs. Tomey Proffitt (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 634 Otsego St., Perryville, MD 21903

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Gdns
Date: 10/23/01
20c. Location - City or Town, State: Aberdeen, MD

21. Signature of Funeral Service Licensee: ▶ Kenneth B. Cargo
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart faifure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBROVASCULAR ACCIDENT.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D42800
29d. Date signed (Month, Day, Year): 10/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas A. Biondo, M.D. 319 S. Union Ave., Havre de Grace, MD 21078

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Fred T. Proffitt 10/20/01 lbd

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35250

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Mary Catherine Patrick	October 17 01	0535 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital	Baltimore	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-26-8672	1☐M 2☒F	87 Yrs.			Jan 6, 1914	Maryland

To Be Completed by Funeral Director

Usuet Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Sykesville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
606 Boulder Court	21784	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	Cotlege (1-4or 5+)		
7		Homemaker	Domestic

17. Fether's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Charles H. Simms	Olive Rebecca Haines

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Ms. Melanie Boone (Granddaughter)	PO Box 306 Sykesville, MD 21784

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Buriat 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Jennings Chapel Cem.	10/20/01	Woodbine, MD

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian A. Haight	HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediete Cause (Finat disease or condition resulting in death)	e. Myocardial Infarct	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	Due to (or as e consequence of):	
	b. Due to (or es a consequence of):	
	c. Due to (or as e consequence of):	
	d.	

tF FEMALE: 23b. Wes decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month / Day / Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) _____ 9☐Unknown	

Pert II. **Othar significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Wes case referred to medical exeminer?	28. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	
	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) end menner as steted.
2☐**Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	RES000	October 17 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sean McGarr, M.D. Sinai Hospital 2401 West Belvidere Ave, Baltimore Maryland 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	▶ Jeanne G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Patrick, Mary Catherine

WIL 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35251

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ELIZABETH JANE PARRISH	OCT. 18, 2001	6:15 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CARROLL COUNTY GEN. HOSPITAL	WESTMINSTER	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-24-8577	1☐ M 2☒ F	72 Yrs.			11/21/1928	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	CARROLL	WESTMINSTER	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
105 E. MAIN ST., APT. 8	21157	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		WAITRESS	RESTAURANT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
DANIEL HENRY PARRISH	AGNES VIOLA GLOS

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY S. RUBY - DAUGHTER	5133 WENTZ RD., MANCHESTER, MD. 21102

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	CARROLL CREMATION	10/19/01	HAMPSTEAD, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John Fletcher	FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD.21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CVA	3 mos
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. ASCVD	10 yr
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ John W. Middleton	D25443	10-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John W. Middleton 688 Poole Road, Westminster Md 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

WSL 2

0128800435 UNIT#03-93-80
PARRISH,ELIZABETH JANE
MIDDLETON,JOHN W
11/21/1928 F
INP 10/15/01

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irene A. Peskoff-Schaffer
2. Date of Death (Month, Day, Year): October 16, 2001
3. Time of Death: 2:05 pm
4a. Facility Name (If not institution, give street and number): 617 Oakdale Drive
4b. City, Town, or Location of Death: Hampstead
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-03-9075
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 24, 1907
9. Birthplace (State or Foreign Country): Wisconsin

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 617 Oakdale Drive
10f. Zip Code: 21074
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tailor
16b. Kind of Business/Industry: Tailoring

17. Father's Name (First, Middle, Last): Henry Bernitt
18. Mother's Name (First, Middle, Maiden Surname): Matilda Mundt

19a. Informant's Name/Relationship (Type, Print): Evelyn Heird, daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 617 Oakdale Drive, Hampstead, MD 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial Park
Date: 10/19 2001
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Steven W Eline MD0723
22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Chronic Obstructive Pulmony Disease	10 years
Due to (or as a consequence of): b.	Sojren's Syndrome	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Hypertension	10 years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anemia. myleodysplosia; Cerebral Vascular event

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B. A. Burke MD
29c. License number: 040223 MD
29d. Date signed (Month, Day, Year): 10/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca A. T. Goedeke, M.D. - 4231 Northwoods Trail - Hampstead, MD 21074

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Medical Certification: To Be Completed by Physician/Medical Examiner

WJR 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35253

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Payne
2. Date of Death (Month, Day, Year): October 27 2001
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 213-01-0365
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 22, 1913
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10799 Hickory Ridge Road
10f. Zip Code: 21044
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronic Technician
16b. Kind of Business/Industry: RCA Corporation

17. Father's Name (First, Middle, Last): Franklin Payne
18. Mother's Name (First, Middle, Maiden Surname): Lucy Gray

19a. Informant's Name/Relationship (Type, Print): Thomas W. Payne/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3323 Hibiscus Court Ellicott City, Maryland 21043

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Mem. Gard.
Date: 11/01/2001
20c. Location - City or Town, State: Marriottsville, Maryland

21. Signature of Funeral Service Licensee: Cindra Amato M00845
22. Name and Address of Facility: Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Congestive heart failure
Due to (or as a consequence of):
c. COPD
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Elizabeth Bower MD
29c. License number: DD55437
29d. Date signed (Month, Day, Year): October 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elizabeth Bower MD 3640 Ellicott Center Dr #103 Ellicott City, MD 21043

State Registrar

31. Date filed (Month, Day, Year): OCT 29 2001
32. Registrar's Signature: Donna G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35254

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Helen A. Rutkowski	October 22 2001	0142 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Campus	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-18-9083	1☐ M 2☑ F	78 Yrs.			June 4, 1923	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Joppa	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2801 Franklinville Road	21085	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th Grade		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Zielinski	Anna (surname Unknown)

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Nancy L. Ertwine (daughter)	2801 Franklinville Rd., Joppa, MD 21085

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Holly Hill Mem'l Gard 10/24/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Carol Blumberg	Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarct — Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Wes decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Hypertension
Coronary Artery Disease

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Exeminer:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mirza A. Baig MD	D43115	10-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
615, S. Union Ave, Havre De Grace, MD, 21078

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 23 2001	Jennie G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Rutkowski, Helen

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35255

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Herbert Rowe

2. Date of Death Month Day Year: October 22 2001

3. Time of Death: 500 PM

4a. Facility Name *(If not institution, give street and number)*: 3700 Laurel Drive

4b. City, Town, or Location of Death: Indian Head

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 215-26-6301

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Feb. 11, 1930

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Indian Head

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3700 Laurel Drive

10f. Zip Code: 20640

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Boiler Operator

16b. Kind of Business/Industry: Pepco

17. Father's Name *(First, Middle, Last)*: Joseph R. McKenzie

18. Mother's Name *(First, Middle, Maiden Surname)*: Rachel Elizabeth Pearl Rowe

19a. Informant's Name/Relationship *(Type, Print)*: Lilliam Pearl Rowe-Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3700 Laurel Drive, Indian Head, MD 20640

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Christ Episcopal Ch. Cem.

Date: 10-26-01

20c. Location - City or Town, State: Accokeek, Maryland

21. Signature of Funeral Service Licensee: John P. Knisley - M01164

22. Name and Address of Facility: Huntt Funeral Home, P. O. Box 156, Waldorf, MD 20604

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Non Hodgkin's lymphoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krish M. Mathur

29c. License number: D2f352

29d. Date signed *(Month, Day, Year)*: 10-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Krishan Mathur, P. O. Box 1703, La Plata, MD 20646

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 25 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35256

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma Ruth Schmidt
2. Date of Death (Month, Day, Year): October 21, 2001
3. Time of Death: 10:15 PM
4a. Facility Name (If not institution, give street and number): 9205 Ravenwood Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-28-9697
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 27, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 9205 Ravenwood Road
10f. Zip Code: 21237
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George C. Flynn
18. Mother's Name (First, Middle, Maiden Surname): Melva Barnes

19a. Informant's Name/Relationship (Type, Print): Mr. Joseph Schmidt (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9205 Ravenwood Rd., Baltimore, MD 21237

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: 10/24/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mark T. [illegible]
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Intarval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. SMALL CELL LUNG CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco usa contributa to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☒Residence 6☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Sein Aung MD
29c. License number: D51555
29d. Date signed (Month, Day, Year): 10/22/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SEIN AUNG, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE MD 21237

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001
32. Registrar's Signature: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35257

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Virginia Elizabeth Strine

2. Date of Death Month / Day / Year: October 17 2001

3. Time of Death: 3:48AM

4a. Facility Name *(If not institution, give street and number)*: Westminster Nursing & Rehabilitative Ctr.

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-28-5031

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 20, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Union Bridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 18 S. Farquhar St.

10f. Zip Code: 21791

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Carroll Reese

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Gartrell

19a. Informant's Name/Relationship *(Type, Print)*: James T. Strine/ son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18 S. Farquhar St. Union Bridge, MD 21791

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Evergreen Mem. Gardens

Date: 10/19/01

20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funeral Service Licensee: Catharina O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 310 Church St. New Windsor, MD 21776

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CVA — 3mos

Due to (or as a consequence of):
b. ASCVD — 25y

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. advanced age — 90y

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CAD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John W. Middleton

29c. License number: D25443

29d. Date signed *(Month, Day, Year)*: 10/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Middleton MD, 688 Poole Rd, Westminster, Md 21157

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001

32. Registrar's Signature: Geneva B Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WOL 2

DHMH 16 Rev 6/95

RJD
01-5953-041
VICKI L.SCOTT

1- For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35258

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VICKI LYNN SCOTT
2. Date of Death (Month, Day, Year): OCTOBER 21, 2001
3. Time of Death: 0205A. M
4a. Facility Name (If not institution, give street and number): OXFORD ROAD AND SPRING ROAD
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 219-60-1610
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 35 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov.10,1965
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 14 Sycamore Avenue
10f. Zip Code: 21601
10g. Citizen of What Country?: United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
18b. Kind of Business/Industry: Coca-Cola Co.

17. Father's Name (First, Middle, Last): T. Richard Scott
18. Mother's Name (First, Middle, Maiden Surname): Andrea Jones Sommers

19a. Informant's Name/Relationship (Type, Print): Andrea J. Sommers/Parent
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3510 Houston Branch RD, Federalsburg, MD 21632

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Spring Hill Cem.
Date: Oct.27,2001
20c. Location - City or Town, State: Easton, Maryland

21. Signature of Funeral Service Licensee: ▶ R Bloade
22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home 216 N. Main St. Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicelions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
e. Multiple Injuries
Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Wes decedent pregnant in the pest 12 months? 1☐Yes 2☐No 9☒Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown
23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probebly 4☐Unknown
24e. Was en autopsy performed? 1☑Yes 2☐No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) (SCENE)
27. Menner of Death 1☐Neturel 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury (Month, Day, Year): 10/21/01
28b. Time of Injury (Found): 1:58 AM M
28c. Injury et Work? 1☐Yes 2☑No
28d. Describe how injury occurred: Driver of motor Vehicle Impacts Tree
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): Oxford Road Talbot County, Maryland

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end menner es steted.
2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: ▶ J Pestaner M.D.
29c. License number: O.C.M.E.
29d. Dete signed (Month, Dey, Yeer): OCTOBER 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 24 2001
32. Registrar's Signature: Irene G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35259

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eileen Marie Seymour
2. Date of Death Month: 10 Day: 12 Year: 2001
3. Time of Death: 3:00 PM
4a. Facility Name (If not institution, give street and number): Future Care of the Chesapeake
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 177-12-5881
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/08/1921
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: PA
10b. County: Bucks
10c. City, Town or Location: Bristol
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 322 Cleveland St.
10f. Zip Code: 19007
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker
16b. Kind of Business/Industry: Textile
17. Father's Name (First, Middle, Last): Paul Jobson
18. Mother's Name (First, Middle, Maiden Surname): Marie Auchenbach
19a. Informant's Name/Relationship (Type, Print): Barbara J. Wilson / Niece inlaw
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 216 Shipping Creek Dr. Stevensville, MD 21666
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Ctr.
Date: 10/15/01
20c. Location - City or Town, State: Chester, MD
21. Signature of Funeral Service Licensee: Thomas K. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 106 Shamrock Road Chester, MD 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — 1 WEEK

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE. 6 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 20 YEARS

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CARCINOMA OF BREAST

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Harjit Singh MD
29c. License number: D14160
29d. Date signed (Month, Day, Year): OCTOBER 12, 2001
30. Name and address of person who completed cause of death (Item 29a) (Type, Print): HARJIT SINGH M.D. 5410-A RITCHIE HIGHWAY, BALTIMORE, MARYLAND- 21225

State Registrar

31. Date filed (Month, Day, Year): OCT 16 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Madge L. Scott
2. Date of Death Month Day Year: Oct 22, 2001
3. Time of Death: 10 am M
4a. Facility Name (If not institution, give street and number): Solomons Nursing Center
4b. City, Town, or Location of Death: Solomons
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 479 18 6937
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 3 1918
9. Birthplace (State or Foreign Country): Iowa

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Iowa
10b. County: Monroe
10c. City, Town or Location: Albia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 509 South 3rd Street
10f. Zip Code: 52531
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Elected Offical/magistrate
16b. Kind of Business/Industry: Government
17. Father's Name (First, Middle, Last): Clarence Robinson
18. Mother's Name (First, Middle, Maiden Surname): Grace Day
19a. Informant's Name/Relationship (Type, Print): Nancy K. Favor- daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 1664 Solomons, MD 20688
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Funeral Service; Date: Oct 23 2001
20c. Location - City or Town, State: Alexandria Virginia
21. Signature of Funeral Service Licensee: ▶ Rausch
22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. rd. Port Republic MD 20676

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Cerebral Edema

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. Metastatic Brain Cancer
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ranjana MD
29c. License number: D53027
29d. Date signed (Month, Day, Year): 23rd October 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Manoj Panwala MD California MD 20619

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001
32. Registrar's Signature: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 17 Rev 1/2001

ORIGINAL

Kenneth D. Thomas
CJ
01-5926-025

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35261

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth Dulaney Thomas
2. Date of Death: Month October Day 19 Year 2001
3. Time of Death: 03:25 P.M
4a. Facility Name (If not institution, give street and number): 3100 Rolling Green Drive
4b. City, Town, or Location of Death: Churchville
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-07-0005
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 30, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Churchville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3100 Rolling Green Drive
10f. Zip Code: 21028
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed
16b. Kind of Business/Industry: Wall Paper Hanger

17. Father's Name (First, Middle, Last): Edward Webster Thomas, Sr.
18. Mother's Neme (First, Middle, Meiden Surneme): Josephine Levinia Litzinger

19a. Informant's Name/Relationship (Type, Print): Kenneth Delf Thomas/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4143 Fox Trail, Havre de Grace, MD 21078

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Hilltop Service Corp. Dete: 10-22 01
20c. Location - City or Town, Stete: Towson, Maryland

21. Signature of Funeral Service Licensee: Miller McComas Perry Jr
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Contact Gunshot Wound of Abdomen

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d. Due to (or as e consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [X] Unknown
24e. Was en autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): Found 10/19/01
28b. Time of Injury: Found 0974R
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject shot self
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): Home
28f. Location (Street end Number or Rural Route Number, City or Town, State): 3100 Rolling Green Drive Churchville Maryland

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es steted. 2 [X] Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kenny
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): October 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Medicine Meeting 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No 2001 35262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Francis Alton Thawley	October 18, 2001	11:15 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Elder Care- Cromwell	Parkville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-01-0250	1☒M 2☐F	82 Yrs.			Dec. 7, 1918	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2826 Mayfield Avenue	21213	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1944-1946	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th Grade		Estimator	Shipyard

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Edward Alton Thawley	Agnes E. Luken

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
Mildred Thawley (Wife)	2826 Mayfield Avenue, Baltimore, Maryalnd 21213

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Most Holy Redeemer	10/22/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Neme and Address of Facility
▶Carol Blumberg	Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lewy Alzheimer Disease — Approximate Interval Between Onset and Death: years

Due to (or as a consequence of):

b. Aspiration Pneumonia — weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c. Dysphagia — weeks

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐Yes 2☑No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶Martha Raymundo, MD	054518	10/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTHA RAYMUNDO 3007 E. Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 23 2001	▶Geneva D Spates

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35263

Charles M. Thrift 577403062

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 DQ

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
CHARLES	MACKIN	THRIFT JR.	10 / 21 / 01	0119 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-40-3062	1 [X] M 2 [ ] F	76 Yrs.			FEB. 22, 1925	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	WORCESTER	BERLIN	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8 MIDSHIP DRIVE	21811	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		SALESMAN	AUTOMOBILE DEALERSHIP

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES MACKIN THRIFT SR.	ANNA LOUISE TREVEY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY LOUISE THRIFT- WIFE	8 MIDSHIP DRIVE BERLIN, MD 21811

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	CREMATORY OF DELMARVA	OCT. 21, 2001	DELMAR, DE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Melissa Kay Haney	BOUNDS FUNERAL HOME 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in death)	a. RENAL FAILURE	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CORONARY ARTERY DISEASE	
	Due to (or as a consequence of): c. EMPHYSEMA	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Felal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Kurt Wehberg, Surgeon	D46536	10/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kurt Wehberg MD, 201 Pine Bluff Rd Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 22 2001	▶ Jennie G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35264

JOSEPH SHERMAN TWILLEY

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JOSEPH SHERMAN TWILLEY	OCT. 20, 2001	10:35 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SALISBURY REHAB & NURSING CENTER	SALISBURY, MD	WICOMICO

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-07-1639	1☒M 2☐F	86 Yrs.			6-20-1915	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
705 JACKSON ST	21804	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		INSPECTOR	FUEL PUMP MANUFACTURER

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GEORGE W. TWILLEY	NELLIE WALLER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARTHA S. TWILLEY - WIFE	705 JACKSON ST SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	PARSONS CEMETERY	10-25-01	SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer's Dementia	yrs
Due to (or as a consequence of):	b. coronary artery disease	yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. emphysema	yrs
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	027549	10/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. ADAMS 104 HEALTHWAY DR SALIS. MD.

10+1VA DQ

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 23 2001	▶ [signature] B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

AVIER TERRELL
JML
01-6098-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 112801: ITEMS #23a, 27, 28a-f per ME 6801 ss

Certificate of Death

Reg. No. 2001 35265

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
AVIER ENAZ TERRELL			10	28	2001	0147 A M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
JOHNS HOPKINS HOSPITAL	BALTIMORE		n/a			

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1 [X] M 2 [ ] F	1 Yrs.	4	25			6-3-2000	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	WICOMICO	SALISBURY	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
536-WINDER ST.	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
N/A		N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHASTIAN DEVON TERRELL	DEENA NICOLE HANDY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DEENA N. HANDY ~ MOTHER	420-DELAWARE AVE. SALISBURY, MD. 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	GREEN ACRES	11/5/2001	SALISBURY, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SMOKE INHALATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No	28. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	10-26-01	11:52p M	1 [ ] Yes 2 [X] No	victim of house fire

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Residence	536 Winder St., Salisbury, Maryland

29a. Certifier (Check only one) — 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E.	October 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 05 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35266

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Pierce Whaley
2. Date of Death (Month, Day, Year): October 22, 2001
3. Time of Death: 7:17 AM
4a. Facility Name (If not institution, give street and number): Manor Care Nursing Center-Rossville
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-28-7599
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 7, 1912
9. Birthplace (State or Foreign Country): Virginia

Usuet Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3 Durban Court, Apt. G
10f. Zip Code: 21236
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondery (0-12):
College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Baltimore County

17. Father's Name (First, Middle, Last): James Iglehart Hudnall
18. Mother's Name (First, Middle, Maiden Surneme): Ruby Miskel Clark

19a. Informent's Name/Reletionship (Type, Print): (husband) Mr. Oscar M. Whaley, Jr.
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3 Durban Ct., Apt. G, Baltimore, MD 21236

20e. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☒ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Morriattico Ch. Cem.
Dete: 10/26/01
20c. Location - City or Town, Stete: Kilmarnock, Virginia

21. Signature of Funeral Service Licensee: ▶ Carol Blumberg
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heert failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth): a. Ischemic Heart Disease — 1 year

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last:
b. Due to (or es a consequence of):
c. Due to (or as e consequence of):
d. Due to (or es e consequence of):

IF FEMALE:
23b. Wes decedent pregnent in the pest 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Liva birth 2☐ Fetal death 3☐ Ectopic pregnency 4☐ Pregnent et time of deeth 5☐ Other (specify) 9☐ Unknown
23d. Dete of delivery: Month / Dey / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the ceuse of deeth? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end ptace, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ S. Raguraj
29c. License number: D 53720
29d. Date signed (Month, Dey, Yeer): 10/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Raguraj MD, 2112 Belair Rd #1, Fallston, MD 21047

State Registrar

31. Date filed (Month, Day, Yeer): OCT 23 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35267

Edrie C. Way

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edrie Clark Way

2. Date of Death (Month, Day, Year): Oct. 24, 2001

3. Time of Death: 5:09 PM

4a. Facility Name (If not institution, give street and number): Civista Medical Center

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 579-03-7663

8. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 21, 1907

9. Birthplace (State or Foreign Country): New Mexico

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Bryans Road

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 5610 Fenwick Rd.

10f. Zip Code: 20616

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registrar - FSI

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Charles S. Clark

18. Mother's Name (First, Middle, Maiden Surname): Mellie Burton

19a. Informant's Name/Relationship (Type, Print): Wanda W. Nesbitt Daughte

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20 Pleasant Hill Rd., Owings Mills, Md. 21117

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Funeral Services, INc.

Date: October 26, 2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: M00668

22. Name and Address of Facility: Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Maryland 20640

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular accident

Due to (or as a consequence of): b. Myocardial infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial fibrillation

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D-0033426

29d. Date signed (Month, Day, Year): 10/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. Larry Jenkins, MD. 111 LaGrange Ave. P.O.Box 2665, LaPlata, Md. 20646

State Registrar

31. Date filed (Month, Day, Year): OCT 25 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35268

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
EILEEN	WHITE	OCT. 19 2001	9:53 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
403 S. MAIN STREET	HEBRON	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-01-6682	1☐ M 2☒ F	81 Yrs.			6-19-1920	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	HEBRON	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
403 S. MAIN STREET	21830	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Reca - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12		SCHOOL BUS DRIVER	COUNTY

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
WALTER DARBY	ALICE COOPER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WAYNE WHITE - SON	305 N. MAIN ST. HEBRON, MD 21830

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, crematory or other placa)	Date	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SPRINGHILL MEM. GARD.	10-23-2001	HEBRON, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Cecal Carcinoma	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Metastate to lung	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of deeth 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No	1☐ Yes 2☐ No

25. Was case raterred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Oate of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined			1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] DO	H54827	10/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL GOLDMAN, DO 100 MILFORD SUITE 202 SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 22 2001	[signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

4DO

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35269

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY MARGARET ZELENKA
2. Date of Death (Month, Day, Year): OCT. 19, 2001
3. Time of Death: 9:00 PM
4a. Facility Name (If not institution, give street and number): CORSICA HILLS NURSING HOME
4b. City, Town, or Location of Death: CENTREVILLE
4c. County of Death: QUEEN ANNE'S

Funeral Director

5. Social Security Number: 213-10-5938
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 2, 1912
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: QUEEN ANNE'S
10c. City, Town or Location: CENTREVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 510 LITTLE EAGLE ROAD
10f. Zip Code: 21617
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REGISTERED NURSE
16b. Kind of Business/Industry: NURSING

17. Father's Name (First, Middle, Last): WILLIAM H. EMERSON
18. Mother's Name (First, Middle, Maiden Surname): MARGARET MARY McDONALD

19a. Informant's Name/Relationship (Type, Print): HOWARD W. ZELENKA/ HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 510 LITTLE EAGLE ROAD, CENTREVILLE, MD 21617

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. PETER'S CEMETERY
Date: 10-22-2001
20c. Location - City or Town, State: QUEENSTOWN, MD

21. Signature of Funeral Service Licensee: Chad M. Helfenbein
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Time of Death - 9am - 10-19-01

SS# 213-10-5938 2/3-10-5938 Dr. Bowyer

Patient: Mary Zelenka 10-22-12 DOB

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. RENAL FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
SACRAL DECUBITUS ULCER
SEPSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D0056076
29d. Date signed (Month, Day, Year): 10/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 420 PENN AVE CENTREVILLE MD 21617 PATRICIA A. BOWYER MD

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item #8 per FHG 801 11/13/01 EW

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35270

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOE EDDIE BOWERS

2. Date of Death: Month NOVEMBER Day 5 Year 2001

3. Time of Death: 0000 HRS M

4a. Facility Name (If not institution, give street and number): ST AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 251-32-3903

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): 04-02-1928

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 812 LYNHURST STREET

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH GRADE

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FORK LIFT OPERATOR

16b. Kind of Business/Industry: MD. DRY DOCK

17. Father's Name (First, Middle, Last): JOHN BOWERS

18. Mother's Name (First, Middle, Maiden Surname): LOTTIE KOONS

19a. Informant's Name/Relationship (Type, Print): CARRIE BOWERS / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 812 LYNHURST ST., BALTO. MD. 21229

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK

Date: 11-10-01

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death): a. METASTATIC COLON CANCER — Approximate Interval Between Onset and Death: MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24e. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D.

29c. License number: P13601

29d. Date signed (Month, Day, Year): NOVEMBER 05 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NANA CESAR, 900 CATON AVENUE, BALTIMORE MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: ▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

BOWERS E. JOE & NAME 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM #29d per phys 6801 111401 SS

Certificate of Death

Reg. No. 2001 35271

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BRENDA MAE BOWIE
2. Date of Death (Month, Day, Year): NOVEMBER 02, 2001
3. Time of Death: 6:03 PM
4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-38-8245
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 60 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-14-1941
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 911 CHANCEY AVENUE
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): HARRY BESSICK
18. Mother's Name (First, Middle, Maiden Surname): BLANCHE JONES

19a. Informant's Name/Relationship (Type, Print): GENERAL BOWIE, SR
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 CHANCEY AVE., BALTO. MD. 21217

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK
Date: 11-07-01
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

To Be Completed by Funeral Director

Brenda Bowie
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY Embolism
Due to (or as a consequence of):
b. BREAST CANCER
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Rashid Haq
29c. License number: P15700
29d. Date signed (Month, Day, Year): 11-02-2001 ~~11-01-2001~~

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rashid Haq M.D. C/o MARYLAND GENERAL Hospital

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: ▶ Geneva D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

#29d

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35272

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara Jeanne Bailey

2. Data of Death: Month November Day 2nd Year 2001

3. Time of Death: 1:40 AM

4a. Facility Name (If not institution, giva street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-68-5674

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 45 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): FEB. 23, 1956

9. Birthplace (State or Foraign Country): Maryland

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7989 Nolpark Court #102

10f. Zip Code: 21061

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, etc. Specify: White

15. Decedant's Education (Specify only highast grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): Nurse

16b. Kind of Businass/Industry: Nursing Home

17. Fathar's Nama (First, Middla, Last): Frank R. Manning

18. Mothar's Nama (First, Middla, Maiden Sumame): Dorothy Louise Wilson

19a. Informant's Name/Ralationship (Type, Print): William Richard Bailey, Jr./husband

19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda): 7989 Nolpark Court #102 Glen Burnie, MD 21061

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of cemetery, crematory or othar place): Metro Crematory, Inc. Data: 11/3/01

20c. Location - City or Town, State: Baltimore, MD

21. Signatura of Funeral Service Licensee: Dawn M. McDonald — Dawn M. McDonald

22. Nama and Addrass of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complicetions that caused tha daath. Do not antar the moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Between Onset and Daath

Immediata Cause (Final disaasa or condition rasulting in death): a. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last:

b. Due to (or as a consequence of): Intestinal perforation

c. Due to (or as a consequance of):

d. Due to (or as a consequance of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yas, outcoma of pregnancy: 1☐ Liva birth 2☐ Fatal daath 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Data of dalivary: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.: Diabetes, Hypertension,

23a. Did tobacco usa contributa to the causa of daath? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of daath? 1☐ Yes 2☒ No

25. Was casa rafarred to medical examiner? 1☐ Yas 2☒ No

28. Place of Daath (Check only ona): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Daath: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not ba datarmined

28a. Date of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Streat and Numbar or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ Certifying Physician: To tha bast of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and due to tha causa(s) and mannar statad.

29b. Signature and title of certifier: , MD

29c. Licensa number: D45006

29d. Data signad (Month, Day, Year): November 2nd, 2001

30. Name and addrass of parson who completed cause of daath (Item 23a) (Type, Print): KOFI BONITEY, 301 Hospital Dr, Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Yaar): NOV 06 2001

32. Registrar's Signatura: D Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

BAILEY, BARBARA

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DHMH 17 Rav 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar REPLACEMENT **Certificate of Death** Reg. No. 01-35273

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
EDWARD ARTHUR BAYER	11 / 05 / 01	5:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ROCK SPRING VILLAGE	FOREST HILL	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
495-14-8363	1 [X] M 2 [ ] F	80 Yrs.			08-30-21	MISSOURI

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Forest Hill	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1 Colgate Drive	21050	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4+	Teacher	Music

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward Frank Bayer	Grace Dobyns

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janet Bayer / daughter	2627 Meredith Rd., White Hall, MD 21161

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Parkway United Church of Christ	11/9/01	St. Louis, Missouri

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Joseph N. Zannino	Joseph N. Zannino Jr. FH, 263 S. Conkling St., Baltimore, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarct	MIN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	Coronary Artery disease	YEARS
Due to (or as a consequence of): c.	Atherosclerotic Cardiovascular disease	YEARS
Due to (or as a consequence of): d.	Hypertension	YEARS

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE
DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) — 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Luis F. Gimenez M.D.	D31960	11/13/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LUIS F. GIMENEZ MD 520 Upper Chesapeake Dr. Suite 312 Bel Air MD 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 20 2001	James D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #28b PER PHY G 801 11/06/01 JH — Certificate of Death — Reg. No. 2001 35274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
CONSTANCE DOROTHEA PERRERA BRASWELL	October 25 2001	1:19 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-32-1681	1☐M 2☒F	66 Yrs.			Sept 23, 1935	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore County	Perry Hall	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5 Joppa Ridge Circle, Apt 2D	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		School Kitchen Manager	County Education Food Service Dept.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Paul Perrera	Dorothy Madeline Roth

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Thomas Braswell	3016 Rosalie Avenue, Baltimore, Maryland 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cremetory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Moreland Mem Park	10/29/2001	Hillendale, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST

Due to (or as a consequence of):
b. Hypovolemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hemorrhage

Due to (or as a consequence of):
d. Right Nephrectomy

Approved Hattie Mills R. Militello, M.D.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Peripheral Vascular Disease

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	October 25 2001	12:00p M	1☐Yes 2☒No	Intraoperative Hemorrhage

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Hospital (Franklin Square)

28f. Location (Street and Number or Rural Route Number, City or Town, State): 9000 Franklin Square Dr. Rosedale Md 21237

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Year)
R Hoofnagle	D35873	October 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Hoofnagle 9000 Franklin Square Dr. Baltimore, Md. 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 6 2001	Jayne D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Constance Braswell

ADH
MICHAEL BALL
01-6160-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35275

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MICHAEL RODNEY BALL	OCTOBER 31, 2001	1715 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
711 SOUTH BOULDIN STREET	BALTIMORE CITY	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-32-6963	1 [X] M 2 [ ] F	66 Yrs.			June 15, 1935	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
711 South Bouldin Street	21224	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 years		Steam Fitter	Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Rodney Ball	Irene Irwin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Deborah A. Hawkins (daughter)	7 Murdock Road Baltimore, Maryland 21212

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Dulaney Valley Memorial Gardens 11-3-01	Timonium, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George Furmanski	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined			1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	OCME	NOVEMBER 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Aaron Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 6 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

01-6219-510
B.K.S
MELVIN G. COX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — Certificate of Death

1- For State Registrar AMND ITM#20b PR. F.H. G801 11-6-01 JAB

Reg. No. 2001 35276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin G. Cox
2. Date of Death Month Day Year: NOV. 3, 2001
3. Time of Death: 0848 A M
4a. Facility Name (If not institution, give street and number): 3527 LIBERTY HEIGHTS AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 245-12-9172
6. Sex: 1 ☐ M 2 ☐ F
7. Age (In yrs. last birthdey) 79 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): May 14, 1922
9. Birthplace (State or Foreign Country): South Carolina

Usuel Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Balto.
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3527 Liberty Heights
10f. Zip Code: 21215
10g. Citizen of Whet Country? U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Collector
18b. Kind of Business/Industry: Junk

17. Father's Name (First, Middle, Last): N/A
18. Mother's Name (First, Middle, Maiden Surname): N/A

19a. Informant's Name/Relationship (Type, Print): Dalvis Brown Caretaker
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 3527 Liberty Heights Ave. Balto. Md. 21215

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): CROWNSVILLE VET. CEM. Garrison Forest Vet. Cem.
Date: Nov. 9 2001
20c. Location - City or Town, State: Anne Arundel Md.

21. Signature of Funeral Service Licensee: Carlton C. Douglas
22. Name and Address of Facility: C. Douglas Funeral Service P.A. Court on McCulloh 1501 McCulloh St. Balto. Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetet deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of deeth 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMER'S DISEASE

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☐ Unknown

24e. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicat examiner? 1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margarita Korell
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): NOV. 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yeer): NOV 0 6 2001
32. Registrar's Signature: Bernice D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): REDESSA L. CLARK
2. Date of Death Month Day Year: 11-04-2001
3. Time of Death: 1:15 PM
4a. Facility Name (If not institution, give street and number): 6615 DALTON DRIVE
4b. City, Town, or Location of Death: GWYNN OAK
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-24-6244
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 90 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-25-1911
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: GWYNN OAK
10d. Inside City Limits: 1☐Yes 2☑No
10e. Street and Number: 6615 DALTON DRIVE
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 9TH GRADE
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSE KEEPING
18b. Kind of Business/Industry: HEALTH CARE

17. Father's Name (First, Middle, Last): UK
18. Mother's Name (First, Middle, Maiden Surname): MARY GOODWIN

19a. Informant's Name/Relationship (Type, Print): LEROY THOMAS / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6615 DALTON DR., BALTO. MD. 21207

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST
Date: 11-13-01
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ADENOCARCINOMA of Colon
Approximate Interval Between Onset and Death: 1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probebly 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical exeminer? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑**Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ CDKearney MD
29c. License number: D0027860
29d. Date signed (Month, Day, Year): November 5th, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER D. KEARNEY MD 700 WASH. BLVD. BALT. MD 21230

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: ▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

REDESSA CLARK.

6

Cleveland Champion
CJ
01-5976-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item26

1- For State Registrar PER VER G801 11/07/01 RR UNPENDED 110601:ITEMS#23a,ptII,27 per HE G801 ss

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35278

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
Cleveland	Champion	October	22	2001	12:25 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5000 Denview Way #K	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
242-24-0457	1[X] M 2[ ] F	77 Yrs.			04 16 24	NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
5000 Denview Way	21206	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	na	Longshoreman	Dry Dock

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wallace E. Pretty	Daisy Adams

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Clifton Champion-Brother	815 Sheppard School Road, Zebulon, NC 27597

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, Stete
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Garrison Forest Vet.	11/8/01	Owings Mills, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Jerome A. Thompson	March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetel deeth 3[ ] Ectopic pregnancy 4[ ] Pregnant et time of deth 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death bul not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE AND GOUT

23e. Did tobecco use contribute to the cause of deeth?	24a. Was en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1[ ] Yes 2[ ] No 3[ ] Probebly 4[X] Unknown	1[X] Yes 2[ ] No	1[X] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)	
1[X] Yes 2[ ] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other (Specify) Scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) end menner as steted.
2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. Kings	O.C.M.E.	October 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	Geneva D Sparks

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35279

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NEIL CICONE

2. Date of Death (Month, Day, Year): OCTOBER 31 2001

3. Time of Death: 4:35 PM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 220-72-4967

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 27, 1959

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 912 Reverdy Road

10f. Zip Code: 21212

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1978-1981

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: Electrical

17. Father's Name (First, Middle, Last): Gaston D. Cicone

18. Mother's Name (First, Middle, Maiden Surname): June Shupp

19a. Informant's Name/Relationship (Type, Print): Kimberly Cicone (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7233 Martell Avenue Dundalk, Maryland 21222

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 11/5/01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 2 WEEKS

Due to (or as a consequence of):

b. ANOXIC BRAIN INJURY — 3 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. MULTI SUBSTANCE ABUSE — 3 WEEKS

Due to (or as a consequence of):

d.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [✓] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [✓] Could not be determined

28a. Date of Injury (Month, Day Year): 9-24-2001

28b. Time of Injury: unk M

28c. Injury at Work? 1 [ ] Yes 2 [✓] No

28d. Describe how injury occurred: UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 912 Reverdy Rd. Balto. Md.

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ayi, MD

29c. License number: P13451

29d. Date signed (Month, Day, Year): NOV 1ST 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BERTHA AYI 5601 LOCH RAVEN BLVD. BALTIMORE, MD 21239. GOOD SAMARITAN HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35280

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BENEDICT, PETER, COTTONE
2. Date of Death: Month 11 Day 04 Year 2001
3. Time of Death: 8.15 PM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 579-52-6549
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 26, 1909
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7110 Minstrel Way
10f. Zip Code: 21045
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5 +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Communications Law

17. Father's Name (First, Middle, Last): Pellegrino Cottone
18. Mother's Name (First, Middle, Maiden Surname): Pellegrina Grisafi

19a. Informant's Name/Relationship (Type, Print): Vincent W. Cottone/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11223 Palatine Avenue North Seattle, WA 98133

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 11-6-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Urosepsis	1 – 2 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rajan MD
29c. License number: D0053709
29d. Date signed (Month, Day, Year): 11/5/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJ. CHAWLA 3060 Mitchellville rd Bowie MD 20716

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

RR

RR 10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35281

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carl Joseph Cooney

2. Date of Death (Month, Day, Year): November 4, 2001

3. Time of Death: 1227pm

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-07-1553

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 30, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3 Summit Hill Court #B-1

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management

16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): Joseph Vincent Cooney

18. Mother's Name (First, Middle, Maiden Surname): Anna Louise Bazzell

19a. Informant's Name/Relationship (Type, Print): Eileen E. Cooney/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Summit Hill Court #B-1 Baltimore, MD 21228

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 11-5-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — ½ hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PACEMAKER

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0051865

29d. Date signed (Month, Day, Year): November 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES CURTIS ST. AGNES HOSPITAL BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

CARL COONEY RR

RP 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JU-CHUN MA CHEN

2. Date of Death: Month NOV Day 3 Year 2001

3. Time of Death: 1430 P M

4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSP

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 151-68-6405

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 9, 1918

9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No X

10e. Street and Number: 9 English Elm Court

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Chinese

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Jing-Fa Ma

18. Mother's Name (First, Middle, Maiden Surname): Unk.

19a. Informant's Name/Relationship (Type, Print): Ching-Nien Chen/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 English Elm Court Catonsville, MD 21228

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date: 11/6/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: James McDonald

Dawn F. McDonald

22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat diseasa or condition resulting in death)

a. METASTATIC CERVICAL CANCER — 15 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

RR

23b. If FEMALE: Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PROBABLE BREAST CANCER

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. SYMD

29c. License number: D39629

29d. Date signed (Month, Day, Year): NOV 3 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. SYMD 10724 LITTLEPATUXENT PKWY COLUMBIA MD 21044

RR 5

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: Sandra D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #20b PER FH G801 11/07/01 JH

Certificate of Death

Reg. No. 2001 35283

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Marie Elizabeth Cullison			2. Date of Death (Month, Day, Year): November 06, 2001	3. Time of Death: 3:30 A.M
4a. Facility Name (If not institution, give street and number): Holly Hill Manor Nursing Home	4b. City, Town, or Location of Death: Lutherville	4c. County of Death: Baltimore County		
5. Social Security Number: 213-03-9453	6. Sex: 1☐ M 2☒ F	7. Age (In yrs. last birthday): 87 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): September 11,1914
9. Birthplace (State or Foreign Country): Waynesboro, PA.				

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore County	Timonium	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11 Dublin Drive	21093	United States of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12): 12	College (1-4or 5+): n/a	Sales	Woolworth Department Stores

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wilfred Dick	Maude Miller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Beverly A. Gauss (Daughter)	11 Dublin Drive Timonium, Maryland 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Green Hill Cemetery	11/08/01	Waynesboro, PA.

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr. — Jeffrey L. Gair, Sr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

Physician /Medical Examiner — **Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cerebrovascular Accident	1 Day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequence of):	
	b. Due to (or as e consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D 17041	Tuesday, November 06, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marc I. Leavey, M.D. 1205 York Road Suite 38 Lutherville, Maryland 21093

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 6 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35284

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
Marian R. Chychota	November 01 2001	01 16 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST AGNES	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (State or Foreign Country)
153-16-8813	1☐M 2☒F	82 Yrs.			May 26, 1919	Penn.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Ellicott City	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2817 Montclair Road	21043	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - Americen Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Cashier	Pantry Pride

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William A. Allspaugh	Verna Dailey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Susan Morris- niece	4122 Mechanicsville Road, Bensalem Penn. 19020

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removel from State 4☐Donetion 5☐Other (Specify)	Garrison Forest Vet. Cem.	11-05-01	Owings Mills, Md.

21. Signature of Funeral Service Licensee ▶ Kim Schlange

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RESPIRATORY FAILURE	16 Hours
Due to (or as e consequence of): b.	SEPSIS	11 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute lo the cause of death?	24e. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐Yes 2☐No 3☐Probebly 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ Rosmary Grannan PA-C IV	P 12591	November 01 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rosmary Grannan ST AGNES HOSPITAL

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	▶ Geneva D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Division of Vital Records, P.O. Box 68760, CHYCHOTA, Marian

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#19b perFHG801 11/17/01 EW

Certificate of Death

Reg. No. 2001 35285

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Marie Chaffman	November 1, 2001	5:15 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Eldercare of Hamilton	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
509-28-9221	1☐M 2☒F	77 Yrs.			10/08/1924	England

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3638 Beech Avenue	21211	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Clerical	S.P.C.A.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Tebbutt	Grace E. Knights

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Tim Chaffman Son	3320 Beech Avenue Baltimore ,MD 21211

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lakeview Mem. Park	11/03/2001	Sykesville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kym Achlanger M0120	Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b. COPD Due to (or as e consequence of):	
	c. Due to (or as a consequence ol):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant el time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death bul not resulting in the underlying cause given in Part I.

HTN

23e. Did tobacco use conlribute lo the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy lindings available prior to completion of cause ol death?
1☐Yes 2☐No 3☒Probebly 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was cese relerred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Rachelle	D56705	11/2/01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RACHELLE GAJADHAR, 3007 E. NORTHERN PKWY, BALTIMORE MD 21214

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
NOV 0 6 2001	▶ Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

N

#19B

6

01-6233-001
B.K.S
DANNY CHRISTIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 111401:ITEMS#23a,b,27 per ME 0801 ss

2001 35286
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Danny Ray Christian	NOV. 3, 2001	1:22 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
232-04-0717	1☒M 2☐F	43 Yrs.			July 10 1958	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
W. Virginia	McDowell	Northfork	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
P.O. Box 566	24868	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wilburn Christian	Ella Lockhardt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ella Christian (mother)	P.O. Box 566, Northfork, W.VA. 24868

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Woodlawn Memorial Pk.	Nov. 08 2001	Bluewell, W.VA.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in death)	a. CARDIAC ARRHYTHMIA	
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Lest	b. DUE TO ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) end menner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ J. Pestana, MD	O.C.M.E	NOV. 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestana 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
NOV 06 2001	▶ D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35287

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RICHARD FOSTER CADIGAN, Sr.

2. Date of Death Month Day Year: November 2, 2001

3. Time of Death: 2:33 P.M.

4a. Facility Name *(If not institution, give street and number)*: St. Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-26-4247

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 9, 1930

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 108 Kenilworth Park Drive

10f. Zip Code: 21204

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 5+ years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Attorney

16b. Kind of Business/Industry: Law

17. Father's Name *(First, Middle, Last)*: Timothy Joseph Cadigan

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Cecelia Foster

19a. Informant's Name/Relationship *(Type, Print)*: Anne Brown (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15901 Irish Ave. Monkton, Maryland 21111

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Memorial Gardens

Date: 11-6-01

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: George J. Fenane

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCT — INSTANT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CARDIOMYOPATHY — 2 YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) end manner stated.

29b. Signature and title of certifier: Walter R Welzant MD

29c. License number: D 12039

29d. Date signed *(Month, Day, Year)*: Nov 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Walter R. Welzant, M.D. 7600 Osler Drive Towson, Maryland 21204

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 06 2001

32. Registrar's Signature: Donna D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.

Important: If item 27 is marked other than "natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35288

Casper, David

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1. Decedent's Name (First, Middle, Last): David Albert Casper		2. Date of Death (Month, Day, Year): October 31 2001	3. Time of Death: 8:04 AM
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER	4b. City, Town, or Location of Death: TOWSON	4c. County of Death: BALTIMORE	
5. Social Security Number: 217-92-8534	6. Sex: 1 [X] M 2 [ ] F	7. Age (In yrs. last birthday): 37 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): April 5, 1964
9. Birthplace (State or Foreign Country): Maryland			

Usual Residence of Decedent

10a. State: Maryland	10b. County: Baltimore	10c. City, Town or Location: Baltimore	10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 144 Dumbarton Rd.	10f. Zip Code: 21212	10g. Citizen of What Country?: United States	

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:	14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self-employed	16b. Kind of Business/Industry: home/grounds improvement	
17. Father's Name (First, Middle, Last): Roger Wilford Casper	18. Mother's Name (First, Middle, Maiden Surname): Doris Margeurite Marsh		
19a. Informant's Name/Relationship (Type, Print): Roger W. Casper/father	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 144 Dumbarton Rd. Baltimore, MD 21212		
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory	Date: 11/5/01	20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: John O. Mitchell IV	22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212		

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hemorrhagic shock	
Due to (or as a consequence of):	b. Esophageal varices	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Chronic liver disease	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic alcohol use

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No	26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. Date of Injury (Month, Day Year) / 28b. Time of Injury M / 28c. Injury at Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G Bedon MD	29c. License number: D12732	29d. Date signed (Month, Day, Year): 11/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE A. BEDON 6701 N. Charles St. Balto Md. 21204

State Registrar

31. Date filed (Month, Day, Year): NOV 0 6 2001	32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35289

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Russell Andrew Duncan	November 2, 2001	2:00p. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2404 E. Branch Road	Dundalk	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
177-18-3399	1☒M 2☐F	79 Yrs.			July 14, 1922	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2404 E. Branch Road	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WW II	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 years		Western Electric Machine Opr.	Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Duncan	Mary Dodson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Catherine A. Duncan (Wife)	2404 E. Branch Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sacred Heart of Jesus	11/6/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephanie Massey	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OESophagus.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Liva birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MTu MD	D0021859.	11-3-01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MOHAMMAD TAQIMD BRENTWOOD MEDICAL CENTER 6710 Holabird Ave Balt MD 21222.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	▶ Geneva G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35290

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Downey

2. Date of Death — Month: November Day: 3 Year: 2001

3. Time of Death: 5:30AM

4a. Facility Name (If not institution, give street and number): Keswick Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 212-20-2499

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): January 31, 1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 700 W. 40th St.

10f. Zip Code: 21211

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): business owner

16b. Kind of Business/Industry: homeowners services

17. Father's Name (First, Middle, Last): Jessie Wright Downey, Jr.

18. Mother's Name (First, Middle, Maiden Surname): May Lee Willis

19a. Informant's Name/Relationship (Type, Print): Harriet S. Downey/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3601 Greenway Unit 410 Baltimore, MD 21218

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Date: 11/6/01

20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: John D. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration pneumonia	9 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Cerebrovascular disease and history of strokes	4 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Isabelle MacGregor MD

29c. License number: D13657

29d. Date signed (Month, Day, Year): November 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ISABELLE MACGREGOR, KESWICK, 700 W-40TH STREET, BALTIMORE, MD 21211

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35291

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN T. DAILY

2. Date of Death (Month, Day, Year): NOVEMBER 3, 2001

3. Time of Death: 1:20 A.M.

4a. Facility Name *(If not institution, give street and number)*: 1724 EDGEWOOD ROAD

4b. City, Town, or Location of Death: LOCH RAVEN VILLAGE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-28-6952

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 4/9/1932

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: LOCH RAVEN VILLAGE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1724 EDGEWOOD ROAD

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: KOREAN

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2 YEARS

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALESPERSON

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: FRANK DAILY, SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: MARTHA MEUSHAW

19a. Informant's Name/Relationship *(Type, Print)*: M. DIANE DAILY WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1724 EDGEWOOD ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: DULANEY VALLEY MEM. GAR.

Date: 11/7/01

20c. Location - City or Town, State: COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Recurrent aspiration pneumonia	one month
Due to (or as a consequence of): b.	Multi infarct dementia	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Diabetes mellitus	10 years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Attending MD

29c. License number: D37016

29d. Date signed *(Month, Day, Year)*: November 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth M. Greene, MD 6701 N. Charles St., Suite 405 Baltimore, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 06 2001

32. Registrar's Signature ▶ Denise B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35292

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Hebert Day SR	Oct 30 2001	702 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Good Samaritan	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577 10 5059	1☒M 2☐F	90 Yrs.			1/4/11	D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
842 GLENWOOD AVE.	21212	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	FOREMAN	I.B.M.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN H. DAY	GRACE E. DAY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LILLIAN DAY	842 GLENWOOD AVE. BALTO. MD. 21212

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	ARBUTUS PARK	11/6/01	ARBUTUS, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ C.A. ESTEP	ESTEP BROTHERS FUNERAL SER. P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Edward Seidel MD	D38956	October 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edward Seidel MD 5601 Loch Raven Blvd. Baltimore MD 21239

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	▶

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

01-6141-510

HENRY DAVIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35293

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Henry	Davis	OCTOBER 30, 2001	6:34P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MARYLAND GENERAL HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
unk	X 1 M 2 F	75 Yrs.			4/1/26	N.Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/C	Baltimore	X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1828 Etting St.	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Labor	Crown Cork& Seal Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Davis	Blanche Dixon Davis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William Davis Brother	4102 Penhurst St, Baltimore, Md. 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify)	Mt. Zion Cenetery	11/3/01	Lansdrown, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Lloyd M. Estep	Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 X Unknown	1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.
2 X Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen Radentz, M.D.	O.C.M.E.	OCTOBER 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	James G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#50

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35294

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anne Therse McGlynn Devlin
2. Date of Death (Month, Day, Year): October 30, 2001
3. Time of Death: 3:42 pm
4a. Facility Name *(If not institution, give street and number)*: 15643 Mews Court
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 149-40-6460
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 16, 1949
9. Birthplace *(State or Foreign Country)*: New York

Usuel Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: LAurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 15643 Mews Court
10f. Zip Code: 20707
10g. Citizen of Whet Country?: U.S.A.
11. Maritet Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clinical Researcher
16b. Kind of Business/Industry: Health Care
17. Father's Neme *(First, Middle, Last)*: Thomas J. McGlynn, Jr.
18. Mother's Name *(First, Middle, Maiden Surneme)*: Irma Veronica Madaras
19a. Informent's Neme/Relationship *(Type, Print)*: MIchele Blair / sister
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 904 Phillip POwers Drive Laurel, Maryland 20707
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Ivy Hill Cemetery — Date: Nov. 2, 2001
20c. Location - City or Town, State: Laurel, Maryland
21. Signeture of Funeral Servica Licansee: [signature] / M00770
22. Name end Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Hepatic Encephalopathy — Hours

Due to (or as e consequenca of):

Sequentielly list conditions, if eny, leeding to immedlete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest:
b. Metastatic Pancreatic cancer — 6 months
Due to (or es a consequence of):
c. Panccreatic Cancer — 6 months
Due to (or as e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: small bowel obstruction; sepsis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medtcal Examtner:** On the besis of exemination end/or tnvestigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Marie A Dobyns MD
29c. License number: D29923
29d. Date signed *(Month, Day, Year)*: 10/31/2001
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): 7350 Van Dusen Rd Laurel, MD 20707

State Registrar

31. Dete filed *(Month, Dey, Year)*: NOV 0 6 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 15

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35295

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLADYS MC DUFFIE

2. Date of Death (Month, Dey, Yeer): NOVEMBER 2, 2001

3. Time of Death: 5:37 P

4e. Facility Name (If not institution, give street end number): LORRAINE FRANK FORD

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 266-22-0344

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 84 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): June 29,1917

9. Birthplace (Stete or Foreign Country): Florida

Usuel Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 4027 Shannon Drive

10f. Zip Code: 21213

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8th; College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Custodian

16b. Kind of Business/Industry: Baltimore City Dept. of Education

17. Fether's Name (First, Middle, Last): James Delaware

18. Mother's Name (First, Middle, Maiden Surname): Mildred Bethel

19a. Informent's Neme/Reletionship (Type, Print): Lorraine Bowles (Daughter)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 4027 Shannon Drive Balto. MD 21213

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Greenmount Cemetery

Dete: Nov.8,2001

20c. Location - City or Town, State: Baltimore,MD

21. Signature of Funeral Service Licensee:

22. Neme end Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME BALTIMORE, MARYLAND @21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funerel director, page 2 should be detached for use es the buriel-transit

23a. Pert I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deeth): e. PNEUMONIA — WEEKS

Due to (or es a consequence of): b. COPD — YRS

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:

Due to (or es e consequence of): c. SMOKING — YRS

Due to (or es e consequence of): d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

DEMENTIA & MARKED CACHEXIA; RENAL INSUFFICIENCY; ANEMIA; ASCVD

23b. Did tobacco use contribute to the cauee of deeth? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☑ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemineticn end/or Investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: MD

29c. License number: D41291

29d. Date signed (Month, Dey, Year): NOVEMBER 5, 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): JONATHAN GITLIN, M.D. 21 CROSSROADS DR #330 OWINGS MILLS 21117

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 06 2001

32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35296

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
ELIZABETH	VIRGINIA	ENGEL	November 3, 2001	11:45 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Elizabeth Rehabilitation And Nursing Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-70-0846	1☐ M 2☒ F	91 Yrs.			Dec. 16, 1909	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3320 Benson Ave.	21227	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1 year	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Thomas George Nicholson, Jr.	Carrie Hamman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Lynda Meade (daughter)	6208 Haddon Ave. Baltimore, Maryland 21212

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Parkwood Cemetery	11-6-01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George J. Ferraro	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. DEMENTIA	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequence of): b.	
	Due to (or es e consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month Dey Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnant at time of deeth 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.
2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
James P. Richardson MD	027394	11/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMES P. RICHARDSON MD 700 GEIPE ROAD, CATONSVILLE, MD 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Matthew Fraling

2. Date of Death — Month: November Day: 01 Year: 2001

3. Time of Death: 04:19 AM

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-26-5040

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): 04-29-1929

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 9800 MENDOZA ROAD

10f. Zip Code: 21133

10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+): 7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIRECTOR VOCATIONAL REHABILITATION

16b. Kind of Business/Industry: BALTO. CITY

17. Father's Name (First, Middle, Last): MATTHEW FRALING SR.

18. Mother's Name (First, Middle, Maiden Surname): PEARL CLARK

19a. Informant's Name/Relationship (Type, Print): VALERIE FRALING, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9800 MENDOZA RD, Randallstown, Md 21133

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 11-8-01

20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: Willie E Howell

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ruptured Abdominal Aortic Aneurysm — 11 HRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Data signed (Month, Day, Year): November 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DANIEL MOST, MD 6000 North Wolfe St Baltimore, MD 21287

State Registrar

31. Data filed (Month, Day, Year): NOV 0 6 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35298

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HILDA EMMA FINK
2. Date of Death: Month Nov Day 5 Year 2001
3. Time of Death: 3:35 AM
4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 220-74-5871
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/05/1906
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 610 DUTCHMANS LANE
10f. Zip Code: 21601
10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12YRS | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): GOTLIEB DIETRICH
18. Mother's Name (First, Middle, Maiden Surname): CHRISTINE VOGELMAN

19a. Informant's Name/Relationship (Type, Print): JOHN G. FINK JR (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 929 ST. MICHAELS,MD. 21663.

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK
Date: 11/12/2001
20c. Location - City or Town, State: BALTO.,MD.

21. Signature of Funeral Service Licensee: William A. Chance III
22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute renal failure — days

Due to (or as a consequence of):
b. hypertensive atherosclerotic cardiovascular disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D25750
29d. Date signed (Month, Day, Year): 11/05/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT SANCHEZ, MD 508 IDLEWILD AVENUE EASTON, MD 21601

State Registrar

31. Date filed (Month, Dey, Year): NOV 0 6 2001
32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Hilda Fink
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35299

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ann Catherine Freeburger	November 4, 2001	8:10 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holly Hill Manor, Inc.	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-14-4849	1☐M 2☒F	79 Yrs.			July 26, 1922	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Towson	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
101 Burke Ave.	21286	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Francis Morrow	Catherine Susanna Kahler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carol Ann Mercer/daughter	21405 Gunpowder Rd. Lineboro, MD 21102

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Parkwood Cemetery	11/7/01	Parkville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John D. Mitchell IV	Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. stroke	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D41104	11.5.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ted Houk MD 7825 York Rd Towson MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	Donna D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35300

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elmer M. Fields
2. Date of Death (Month, Day, Year): November 2, 2001
3. Time of Death: 4:00 p.m.
4a. Facility Name *(If not institution, give street and number)*: Gilchrist Hospice Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-12-5728
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01/26/1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1904 Lismore Lane
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager
16b. Kind of Business/Industry: Bell Atlantic

17. Father's Name *(First, Middle, Last)*: Elmer Fields
18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Simms

19a. Informant's Name/Relationship *(Type, Print)*: Jane Francis Fields Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1904 Lismore Lane Catonsville, MD 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crestlawn Mem. Gardens
Date: 11/6/01
20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: ▶ Edison M. Perkins
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. colon cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D0051926
29d. Date signed *(Month, Day, Year)*: November 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M Gordon MD 6565 N. Charles St, Baltimore, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 06 2001
32. Registrar's Signature: ▶ [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Fields, Elmer 11/2/01 4pm

DOB 1/26/25

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35301

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lena Mary Fondnazio

2. Date of Death (Month, Day, Year): October 22, 2001

3. Time of Death: 7:08pm

4a. Facility Name (If not institution, give street and number): 4 Ballycruy Court

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-14-0089

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Jan 15, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4 Ballycruy Court

10f. Zip Coda: 21093

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Carmelo Curreri

18. Mother's Name (First, Middle, Maiden Surname): Theresa Cimino

19a. Informent's Name/Relationship (Type, Print): Josephine F. Sjolander/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Ballycruy Court, Timonium, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer

Date: 10/26/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Lowell M. Lemmon

22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not anter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaase or condition resulting in death): a. alzheimers dx

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Mark Lamos MD

29c. License number: D 34521

29d. Data signad (Month, Day, Year): 10/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark A. Lamos, M.D. 9 Schilling Road, Hunt Valley MD 21031

State Registrar

31. Date filed (Month, Day, Year): NOV 0 6 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35302

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Gill

2. Date of Death: Month November Day 2 Year 2001

3. Time of Death: 2:44 PM

4a. Facility Name (If not institution, give street and number): Doctor Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 215-66-3836

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02-04-42

9. Birthplace (State or Foreign Country): NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 5415 Bucknell Road

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: North Brook Management

17. Father's Name (First, Middle, Last): Roland Gill

18. Mother's Name (First, Middle, Meiden Surname): Lilian Hood

19a. Informant's Name/Relationship (Type, Print): McClerin Gill

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2033 N. Washington Street Baltimore, MD. 21213

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus Cem.

Date: 11-10-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Gladys Warner

22. Name and Address of Facility: Baltimore, Maryland 21202 March F.H., East 1101 E. North Avenue

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arrythmia — MINS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction — Hrs

Due to (or es e consequence of):

c. Hypertension — Years

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24e. Was en autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ Jeffrey A Hong MD

29c. License number: D33983

29d. Date signed (Month, Dey, Year): 11/2/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey Hong 8118 Goodluck Road Lanham, Maryland

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: ▶ Jennie D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM #30 per DVR G801 110601 SS

Certificate of Death

Reg. No. 2001 35303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine T. Green
2. Date of Death Month Day Year: 11-03-2001
3. Time of Death: 5:10 AM
4a. Facility Name (If not institution, give street and number): 8515 GREENS LANE
4b. City, Town, or Location of Death: WOODLAWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-38-4108
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 59 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-15-1942
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: WOODLAWN
10d. Inside City Limits: 1☐Yes 2☑No
10e. Street and Number: 8515 GREENS LANE
10f. Zip Code: 21244
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BAR MAID
16b. Kind of Business/Industry: BAR

17. Father's Name (First, Middle, Last): EDWARD SHIELDS
18. Mother's Name (First, Middle, Maiden Surname): THELMA PRICE

19a. Informant's Name/Relationship (Type, Print): GEORGE GREEN
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8515 GREENS LANE, BALTO. MD. 21244

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL
Date: 11-08-01
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C. Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 6151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of the Lung — Approximate Interval Between Onset and Death: 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Lawrence F. Solomon
29c. License number: D16522
29d. Date signed (Month, Day, Year): November 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence F. Solomon, 1838 Greene Tree Rd., Ste. 300, Balto., MD 21208

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: ▶ Jenna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

C. Green.

5

01-6122-510
crn
Morris Graham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS#10e,18 per fh G801 110601 SS

Certificate of Death

Reg. No. 2001 35304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Morris	Graham	October 29, 2001	9:38 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-96-6840	1 X M 2 ☐ F	23 Yrs.			09 07 78	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Essex	1 ☐ Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24 ~~Edd~~ Ebb Tide Ct.	21221	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☑ Married X 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th grade	na	Laborer	Landscaping

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Morris H. Graham II	~~Joan Wortthington~~ Joan Worthington

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cheryl Graham-Wife	24 Ebb Tide Ct. Essex, Maryland 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Voshell Cemetery	11/5/01	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Lynette K. Jones	March F/H West 4300 Wabash Ave, Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Gunshot Wounds	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No	1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☒ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	10/29/01	8:58 PM	1 ☐ Yes 2 ☑ No	Subject Shot

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Street	Greenmount and East Chase St, Baltimore, Md

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Pestaner M.D.	O.C.M.E.	October 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 6 2001	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35305

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
FREDERICK L. GRANT JR.	NOVEMBER 4 2001	1:42 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GOOD SAMARITAN HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-46-6313	1☒M 2☐F	56 Yrs.			11/20/1944	WASH. D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15 CHARLES PLAZA	21201	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
13yrs		COURIER	NEWSPAPER

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FREDERICK L. GRANT SR.	EMILY CROSS GRANT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
EMILY C. GRANT(MOTHER)	15 CHARLES PLAZA BALTIMORE,MD. 21201.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	DRUID RIDGE	11/07/2001	PIKESVILLE,MD.

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
William C. Lawson III	HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Due to (or as a consequence of): — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as e consequence of):

d. ____

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	28. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 8☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Joshua Martin Ruberfeld	D0057619	November 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSHUA MAR KISS RUBERFELD 4746 RAMS HORN ROW ELLICOTT CITY 21042.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	Donna D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35306

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
HEDWIG	GORSKY	November 4, 2001	5:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Augsburg Lutheran Home	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-05-6627	1☐M 2☒F	92 Yrs.			1-26-1909	Germany

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6811 Campfield Road	21207	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN	UNKNOWN UNKNOWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rev. Otfried O. Arndt (PR)	202-2D Juneberry Way, Glen Burnie, Md. 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	11-6-01	Towson, Maryland 21204

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wallace S. Brooks, Jr.	Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial infarction	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Coronary artery disease	years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

RR

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D37573	November 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jef Tibell MD 25 Main St. Reisterstown MD 21136

RR 12

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	▶ D Sparks

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35307

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Nicholas John Gayo	Nov. 3, 2001	5:45am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Westminster Nursing & Conv. Ctr.	Westminster	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs, last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-07-7939	1 [X] M 2 [ ] F	84 Yrs.			Feb. 2, 1917	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Owings Mills	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
815 Academy Ave.	21117	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Radio Operator	Bendix Corp.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Nick Gayo	Anna Walk

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Matilda Gayo - Wife	815 Academy Ave., Owings Mills, Md. 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Evergreen Mem. Gardens	Nov. 5, 2001	Finksburg, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
H. J. Eckhardt	Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASCVD	2 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Diabetes	2 yrs
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
John W. Middleton	D25443	11/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John W. Middleton 688 Pole Road, Westminster, Md 21157

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	Geneva D. Sparks

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

David R. Garmer
CJ
01-6246-005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 120401:ITEMS#23a,27,28a-f per ME G802 ss

2001 35308
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Dete of Death Month / Day / Year	3. Time of Death
David Robert Garmer	November 04 2001	06:40 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5111 North Point Boulevard	Sparrows Point	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
220-82-5267	1 M 2 F	41 Yrs.			Feb. 4, 1960	Maryland

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
1605 Inverness Ave.	21222	U.S.A.

11. Mantel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12	8	Computer Programer	Bethlehem Steel Corp.

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Robert Ernest Garmer	Charlotte Hann

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Charlotte Garmer - mother	1440 Fairmount Rd. Hampstead, Md. 21074

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1 X Buriel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify)	New Lutheran Cem.	Nov. 7,2001	Manchester, Md.

21. Signature of Funerel Service Licensee	22. Name and Address of Facility
J. Smith Eckhardt	Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, Md. 21102

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death): a. MULTIPLE INJURIES

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1 Yes 2 X No 3 Probebly 4 Unknown

24a. Was en autopsy performed? 1 X Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No	26. Ptace of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 X Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 X Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	Found: 11-4-01	Found: 5:30a M	1 X Yes 2 No	Subject precipitated from a height

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Bethlehem Steel Plant	5111 N. Point Blvd., Sparrows Point, MD

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end manner es stated. 2 X Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
J. M. [illegible]	O.C.M.E.	November 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
NOV 06 2001	Jennie G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35309

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DUANE GOOCH

2. Date of Death Month Day Year: October 30, 2001

3. Time of Death: 0844 M

4a. Facility Name (If not institution, give street and number): St. Agnes Healthcare

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 211-26-4321

6. Sex: 1 M 2 F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB 17 1933

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 Yes 2 No

10e. Street and Number: 2912 PARKWOOD AVENUE

10f. Zip Code: 21217

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 50/54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Reca - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUS DRIVER

16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Neme (First, Middle, Last): GEORGE GOOCH

18. Mother's Neme (First, Middle, Maiden Surname): LAURA MYERS

19a. Informent's Name/Reletionship (Type, Print): John E. Gooch/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 190 N Oberlin RD., Oberlin, OH., 44074

20a. Method of Disposition: 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other placa): METRO CREMATORY

Dete: 11-02-01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles L. Powell

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth): a. Acute Pulmonary Edema — 2 hour

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last:

b. Due to (or es e consequenca of):

c. Due to (or as e consequenca of):

d. Due to (or as e consequenca of):

IF FEMALE:

23b. Wes decedent pregnant in the pest 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal deeth 3 Ectopic pregnancy 4 Pregnent at time of deeth 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

End Stage Renal Disease. Hypertension. Diabetes

23e. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probebly 4 Unknown

24a. Wes en autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yes 2 No

25. Was case referred to medical exeminer? 1 Yes 2 No

26. Placa of Death (Check only one): Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Menner of Deeth: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and menner es steted. 2 **Medical Examinar:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: MD

29c. License number: BT584B648

29d. Date signed (Month, Day, Year): October 30, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): St Agnes Hospital. Dr. Brummald Rob MD. St Agnes Hospital. 900 Caton Avenue Baltimore MD 21229

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: Patricia D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

NAME Gooch, Duane

Dr HI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #29c&d PER PHY G801 11/14/01 JH

Certificate of Death

Reg. No. 2001 35310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
NORMA L. GRANT	NOVEMBER 4, 2001	2:00 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2333 LAURETTA AVENUE	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-32-4876	1☐M 2☒F	65 Yrs.			JUL. 31, 1936	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2333 LAURETTA AVENUE	21216	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	0	CASHIER	BALTIMORE GAS & ELECTRIC COMPANY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
NAPOLEON HANKS	JO HORTON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOHNNIE MAE STEVENS (SISTER)	3918 EDMONDSON AVENUE BALTIMORE, MD 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Dete	20c. Location - City or Town, Steta
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT. ZION CEMETERY	11/01/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Feciility
▶	WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each fine.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage of Acquired Immunodeficiency Syndrom
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcoma of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant et time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23a. Did tobecco usa confribute to the cause of death?	24e. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of daath?
1☐Yes 2☐No 3☐Probebly 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Homa 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner es steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A. Mrowiec M.D	D47804	11/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. MROWIEC 1940 W. Baltimore ST. Baltimore MD 21223

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	▶ Bernice G. Sparks

#29c
#28

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35311

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther Jane Hope

2. Date of Death: Month Nov. Day 02, Year 2001

3. Time of Death: 9:00pm

4a. Facility Name (If not institution, give street and number): Jospeh Ritchie Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-20-6487

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 03-25-27

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2221 Booth Street

10f. Zip Code: 21213

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Naver Marriad 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 7th Grade; College (1-4or 5+): NA

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Baker

16b. Kind of Business/Industry: Belmar Bakery

17. Fathar's Nama (First, Middle, Last): Will Bagwell

18. Mother's Name (First, Middle, Maiden Sumame): Annie Glenn

19a. Informant's Name/Relationship (Type, Print): James Hope

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212: 1015 E. Northern Parkway Baltimore, MD.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Mt. Zion Cemetery Date: 11-08-2001

20c. Location - City or Town, State: Lansdowne, MD

21. Signatura of Funaral Sarvice Licensae: ▶ Glenda Warner

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused tha death. Do not enter the moda of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of lung — 6 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Dua to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☐ No

26. Plece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Hospice

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) end manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, In my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John W. Payne, MD

29c. License number: D13012

29d. Date signed (Month, Day, Year): 11/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Payne, MD 6565 N. Charles St. Balto, Md 21204

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

9pm 11-2-01 Esther Hope

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35312

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALICE MILDRED HIGINBOTHOM

2. Date of Death: Month November Day 3 Year 2001

3. Time of Death: 2:00PM

4a. Facility Name *(If not institution, give street and number)*: Keswick

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-48-3340

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 22, 1903

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 700 West 40th. Street

10f. Zip Code: 21211

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Frank H. Bartholomee

18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Hoover

19a. Informant's Name/Relationship *(Type, Print)*: William Higinbothom (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1218 Ridervale Road Baltimore, Maryland 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Druid Ridge Cemetery

Date: 11-6-01

20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: George J. Ferrante

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Vascular dementia — 5 years

Due to (or as a consequence of):

b. Multiple Cerebral infarcts — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Isabelle MacGregor MD

29c. License number: D13657

29d. Data signed *(Month, Day, Year)*: November 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M ISABELLE MacGREGOR, KESWICK, 700 W. 40th Street, Baltimore, Md 21211

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 0 6 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35313

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles M. Hartley
2. Date of Death: Month NOVEMBER Day 4 Year 2001
3. Time of Death: 2230HRS
4a. Facility Name (If not institution, give street and number): ST AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 215-09-9520
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 17, 1915
9. Birthplace (State or Foreign Country): Baltimore

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1 Marathon Ct., Apt. 1-A
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Railroad Conductor
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): George Hartley
18. Mother's Name (First, Middle, Maiden Surname): Sophia Ciemny

19a. Informant's Name/Relationship (Type, Print): Jane Amtmann - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1312 Ridge Road, Catonsville, MD. 21228

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balt.,Wash. Crematory
Date: Nov. 07, 2001
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ Wanda L Lemmer
22. Name and Address of Facility: Witzke Funeral Home of Catonsville, 1630 Edmondson Ave., Catonsville, MD. 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. VENTRICULAR FIBRILLATION — MINUTES

Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ N Ceasar M.D.
29c. License number: P13601
29d. Date signed (Month, Day, Year): NOVEMBER 4 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NANA CEASAR; 900 CATON AVENUE, BALTIMORE, MARYLAND 21229

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,
NAME

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HARTLEY
CHARLES M.
16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35314

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Harmon
2. Date of Death: Month November Day 3 Year 2001
3. Time of Death: 10:50 PM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-12-9103
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 17, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No XX
10e. Street and Number: 5924 Smith Avenue
10f. Zip Code: 21209
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Thomas O'Rourke
18. Mother's Name (First, Middle, Maiden Surname): Margaret Cullen

19a. Informant's Name/Relationship (Type, Print): Barry G. Harmon Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5926 Smith Avenue Baltimore, Maryland 21209

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 11/6/01
20c. Location - City or Town, State: Pikesville, MD

21. Signature of Funeral Service Licensee: Barry H. Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Respiratory Failure probable to Acute Respiratory Distress Syndrome
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Dey Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Non Small Cell lung cancer

23e. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J M Gonzalez MD
29c. License number: RES 000
29d. Date signed (Month, Dey, Year): November 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUAN M GONZALEZ MD Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Dey, Yeer): NOV 0 6 2001
32. Registrar's Signature: Sonya D Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Pt known as Harmon, Mary

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35315

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
CATHERINE	M.	HENRY	October 30 2001	3:00 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FutureCare-Sandtown/Winchester	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-12-4597	1☐M 2☒F	94 Yrs.			JUN 6 1907	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2404 ARUNAH AVENUE	21216	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown		DOMESTIC	PRIVATE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
PERCY BORRON	FLORENCE NEWMAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marian Graham/Daughter	3315 Brighton St., Baltimore, Maryland 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	ARBUTUS MEMORIAL	11-2-01	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles A Powell

22. Name and Address of Facility: CHARLES H POWELL FUNERAL SERVICES 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Ovarian Cancer	2 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Atrew edentia dysuria	10 yrs
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	26f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] physician	D29769	10/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): marcelino D. Alboverne 516 N. Rolling Rd Balto MD 21229

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	[signature] Sparks

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35316

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANDREW JACKSON

2. Date of Death: Month NOVEMBER Day 04 Year 2001

3. Time of Death: 6:10 PM

4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-03-8986

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-27-1917

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 923 N. CENTRAL AVE

10f. Zip Code: 21202

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER

18b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name (First, Middle, Last): ROBERT JACKSON

18. Mother's Name (First, Middle, Maiden Surname): CARRIE GARRETT

19a. Informant's Name/Relationship (Type, Print): GRACE JARBOI, NIECE

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 923 N. CENTRAL AVE, BALTO. MD 21202

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT ZION

Date: 11-10-01

20c. Location - City or Town, State: MARYLAND

21. Signature of Funeral Service Licensee: Willie E Howell

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO.MD 21207

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PROSTATE CANCER with METASTASIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)

Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Seyid Arain MD.

29c. License number: P15693

29d. Date signed (Month, Day, Year): 11-04-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Seyid Arain M.D. C/O MARYLAND GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: Bonnie B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

ANDREW JACKSON
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35317

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Layla Cleo Jackson
2. Date of Death (Month, Day, Year): October 27, 2001
3. Time of Death: 14:05
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: NONE
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 0 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours 20 / Min. 27
8. Date of Birth (Month, Day, Year): 10/26/2001
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3000 Mahonia Way
10f. Zip Code: 21040
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A
17. Father's Name (First, Middle, Last): Walter Jackson
18. Mother's Name (First, Middle, Maiden Surname): Sherley Legrand
19a. Informant's Name/Relationship (Type, Print): NIKKI CHILCOAT (STAFF)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6701 N. CHARLES ST., TOWSON,MD., 21204
20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY
Date: 11-02-01
20c. Location - City or Town, State: BALTO.,MD.21202
21. Signature of Funeral Service Licensee: ▶ R. H. Run
22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	HYPOTENSION	16 HRS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	SEPSIS	16 HRS
Due to (or as a consequence of):		
c.	EXTREME PREMATURITY	16 HRS
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: MATERNAL CHORIOAMNIONITIS

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jeffrey Pomerance, M.D.
29c. License number: D51676
29d. Date signed (Month, Day, Year): 10/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey Pomerance MD - GBMC 6701 N Charles St., Rm 2358

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: ▶ [illegible] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Layla Cleo Jackson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35318

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Anthony Jones
2. Date of Death Month: OCT. Day: 31 Year: 2001
3. Time of Death: 10:30 PM
4a. Facility Name (If not institution, give street and number): 11600 Belair Rd.
4b. City, Town, or Location of Death: Baltimore County
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-38-1845
6. Sex: [X] 1 M [ ] 2 F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov.15,1941
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: [X] 1 Yes [ ] 2 No
10e. Street and Number: 3318 Chesterfield Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: [ ] 1 Never Married [X] 2 Married [ ] 3 Widowed [ ] 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? [ ] 1 Yes [X] 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11 yrs.
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Draftsman
16b. Kind of Business/Industry: Bethlehem Steel Corp.

17. Father's Name (First, Middle, Last): James W. Jones, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Margaret Foard

19a. Informant's Name/Relationship (Type, Print): Rose B. Jones (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3318 Chesterfield Avenue Baltimore, Md. 21213

20a. Method of Disposition: [ ] 1 Burial [X] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 11-5-01
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death):
a. MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: 24 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b. HYPERTENSION — 8 YRS
Due to (or as a consequence of):
c. DIABETES (NIDDM) — 9 YRS
Due to (or as a consequence of):
d. HYPERCHOLESTEROLEMIA

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? [ ] 1 Yes [ ] 2 No [ ] 9 Unknown
23c. If yes, outcome of pregnancy: [ ] 1 Live birth [ ] 2 Fetal death [ ] 3 Ectopic pregnancy [ ] 4 Pregnant at time of death [ ] 5 Other (specify) [ ] 9 Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? [X] 1 Yes [ ] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No
24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [X] 2 No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

28. Place of Death (Check only one)
Hospital: [ ] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA
Other: [ ] 4 Nursing Home [ ] 5 Residence [X] 8 Other (Specify) FOUND DEAD IN HIS

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? [ ] 1 Yes [ ] 2 No
28d. Describe how injury occurred: AUTOMOBILE
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D12399
29d. Date signed (Month, Day, Year): NOVEMBER 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES O. DONOVAN IV MD 6516 N. CHARLES ST #509 BALTIMORE, MD 21204

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN T. KING, III

2. Date of Death (Month, Day, Year): NOVEMBER 2 2001

3. Time of Death: 4:00 PM

4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 412-16-1314

8. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09-28-1917

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 830 WEST 40th. STREET

10f. Zip Code: 21211

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married XX Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 No If Yes, Give Year or Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXECUTIVE

16b. Kind of Business/Industry: BALTIMORE GAS AND ELECTRIC COMPANY

17. Father's Name (First, Middle, Last): JOHN T. KING, JR.

18. Mother's Name (First, Middle, Maiden Surname): CHARLOTT MARKELL BAKER

19a. Informant's Name/Relationship (Type, Print): LEIGHTON K.WHEELER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115 HAWTHORN ROAD, BALTIMORE, MD., 21210

20a. Method of Disposition: 1 Burial XX Cremation 3 Removal from State 4 Donetion 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): GREEN MT. CREMATORY

Date: 11-05-01

20c. Location - City or Town, State: BALTIMORE, MD., 21202

21. Signature of Funeral Service Licensee: R. H. Kutt

22. Name and Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD, BALTIMORE, MARYLAND, 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — Approximate Interval Between Onset and Death: 4 DAYS

Due to (or as a consequence of):

b. PNEUMONIA — 10 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. DEMENTIA — UNKNOWN

Due to (or as a consequence of):

d. COLON MASS — UNKNOWN

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 ✓ No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 ✓ No

25. Was case referred to medical examiner? 1 Yes 2 ✓ No

26. Place of Death (Check only one): Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ✓ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: AT2438946

29d. Date signed (Month, Day, Year): NOVEMBER 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 201 EAST UNIVERSITY PARKWAY BALTIMORE MD 21218, ANGELA LEE

State Registrar

31. Date filed (Month, Day, Year): NOV 0 6 2001

32. Registrar's Signature: Jenna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35320

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA KIRK
2. Date of Death (Month, Day, Year): NOVEMBER 3, 2001
3. Time of Death: 10:25 AM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-86-8784
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 20, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Rockdale
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 8009 Windsor Mill Road
10f. Zip Code: 21244
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th Grade
College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Chester A. Williams
18. Mother's Name (First, Middle, Maiden Surname): Elsie Virginia Bowen

19a. Informant's Name/Relationship (Type, Print): Roland Donald Kirk - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8009 Windsor Mill Road; Rockdale, Maryland 21244

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore/Wash. Crem.
Date: 11/7/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133
M00869

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon CA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] A.P. - IMPERIAL — NEO HC
29c. License number: D44505
29d. Date signed (Month, Day, Year): November 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: [signature] Geneva D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35321

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): George Kates

2. Date of Death Month: November Day: 02 Yeer: 01

3. Time of Death: 8:08p M

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore.

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: City

Funeral Director

5. Social Security Number: 220-22-2552

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 11, 1927

9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 116 Cedarmere Rd.

10f. Zip Code: 21117

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Freight Company

17. Father's Name (First, Middle, Last): James Kates

18. Mother's Neme (First, Middle, Meiden Surneme): Ida Marie Chaney

19e. Informant's Neme/Relationship (Type, Print): Betty J. Kates - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 116 Cedarmere Rd., Owings Mills, Md. 21117

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Dete: Nov. 3, 2001

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signeture of Funerel Service Licensee: H.J. Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death)

a. Cardiogenic Shock.

Due to (or as a consequence of):

b. Coronary artery disease.

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Due to (or es e consequence of):

c. Coronary Artery bypass Surgery.

Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnency: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnent et time of deeth 5 [ ] Other (specify) 9 [ ] Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24e. Was en autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yes 2 [✓] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Deeth (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menper of Death: 1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner as steted. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Sequeira M.D.

29c. License number: D0024776

29d. Date signed (Month, Day, Year): November-02-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alejandro Sequeira MD. Sinai Hospital of Baltimore.

State Registrar

31. Dete filed (Month, Day, Year): NOV 0 6 2001

32. Registrar's Signature: Donna P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35322

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: William Lockett, Sr.

2. Data of Death Month Dey Year: Nov. 05, 2001

3. Time of Deeth: 11:30am

4e Facility Neme *(If not institution, give street and number)*: Joseph Ritchie Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 225-36-6107

6. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: 09-25-31

9. Birthplace *(State or Foreign Country)*: VA

Usuel Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX Yes 2☐No

10e. Street and Number: 1400 E. Madison Street Apt.1115

10f. Zip Code: 21205

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Giva Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: School Bus Driver

16b. Kind of Business/Industry: City Wide Transportation

17. Fether's Neme *(First, Middle, Last)*: Johnnie Brown

18. Mother's Nema *(First, Middle, Maiden Surname)*: Rosa Jones

19e. Informent's Name/Reletionship *(Type, Print)*: Sallie Lovelist

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1400 E. Madison Street Apt. #811 Baltimore, MD.

20a. Method of Disposition: XX 1☐Buriel 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Crownsville VA Cemetery

Dete: 11-08-2001

20c. Location - City or Town, State: Crownsville, MD.

21. Signetura of Funaral Servica Licensaa: ▶ Gladys Warner

22. Neme end Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that causad tha daath. Do not anter tha moda of dying, such es cerdiac or respiretory errest, shock, or heert leilure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in death) e. Upper gastrointestinal bleeding — 12 days

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

b. Bleeding Stomach Ulcer — 12 days

Due to (or es e consequence of):

c. Cancer of the prostate ē metastacie to bones — 3 years

Due to (or as e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Pert I.

Tumor of the esophague

Anemia

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveilable prior to completion of causa of deeth? 1☐Yes 2☒No

25. Wes case refarred to medical exeminer? 1☐Yes 2☒No

26. Piece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* HOSPICE

27. Menner of Deeth: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner es stated. 2☐**Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et tha time, dete end place, and due to the ceuse(s) and menner steted.

29b. Signetura and titla of certifier: ▶ Lydia M Jumamoy, M.D.

29c. License number: D0022488

29d. Date signed *(Month, Day, Year)*: NOV. 5, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): LYDIA M. TUMAMOY, M.D. 220 TUNBRIDGE ROAD; BALTIMORE, MD. 21212

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 06 2001

32. Registrar's Signeture: ▶ Denise D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

11/5/01 11:30am

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

William Lockett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35323

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM MILLER JR
2. Date of Death Month Day Year: 11-02-2001
3. Time of Death: 2:30 PM
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL
4b. City, Town, or Location of Death: HOWARD
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 407-14-6509
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 85 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-03-1916
9. Birthplace (State or Foreign Country): GA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1204 CHERRY HILL RD. #B
10f. Zip Code: 21225
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SHERIFF
18b. Kind of Business/Industry: BALTO. CITY

17. Father's Name (First, Middle, Last): WILLIAM MILLER, SR
18. Mother's Name (First, Middle, Maiden Surname): SARAH ROBINSON

19a. Informant's Name/Relationship (Type, Print): MARVENISE HARRIS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061: 8082 MONTAQUE CT., GLEN BURNIE MD

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CROWNSVILLE
Date: 11-07-01
20c. Location - City or Town, State: CROWNSVILLE, MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Respiratory Failure — 1 Hours
Due to (or as a consequence of): b. Pneumonia — Days
Due to (or as a consequence of): c. Generalized Debility — Yrs
Due to (or as a consequence of): d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnency 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failure

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. 2 ☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Kevin M. Cooke, MD
29c. License number: D25770
29d. Date signed (Month, Day, Year): 11/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KEVIN COOKE MD HoCo GENERAL COLUMBIA MD 21044

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: ▶ Geneva M Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35324

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Griffith Martin
2. Date of Death (Month, Day, Year): November 3, 2001
3. Time of Death: 1:27 PM
4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-10-3847
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 17, 1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6451 N. Charles St. #112
10f. Zip Code: 21212
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: supervisor
16b. Kind of Business/Industry: U. S. Govt.-social sec.

17. Father's Name *(First, Middle, Last)*: Hugh Jones Griffith
18. Mother's Name *(First, Middle, Maiden Surname)*: Octavia Douglas Allen

19a. Informant's Name/Relationship *(Type, Print)*: Paula Greenwald/niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6619 S. Dixie Hwy. P. O. Box 192 Miami, FL 33143

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Memorial Ga.
Date: 11/7/01
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: John D. Mitchell IV
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CVA — days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHF, Renal Failure, CASHD with ischemic cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen M Gordon
29c. License number: D0051926
29d. Date signed *(Month, Day, Year)*: November 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen M. Gordon 6565 N. Charles St Baltimore MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 0 6 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1:34 PM

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

N MARTIN Margaret 11-3-01

13

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#17,18,19a perINFG801 11/20/01 EW

Certificate of Death

Reg. No. 2001 35325

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rhoda B. Minetree

2. Date of Death: Month: October Day: 30 Year: 2001

3. Time of Death: 4:35 pm

4a. Facility Name (If not institution, give street and number): Edenwald

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-14-9054

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07/19/1911

9. Birthplace (State or Foreign Country): CALIFORNIA

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 800 SOUTHERLY RD

10f. Zip Code: 21286

10g. Citizen of What Country? USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): EDWARD ~~LUDLUM~~ Ludlam BLOSSOM

18. Mother's Name (First, Middle, Maiden Surname): MAUDE ~~BAYLESS~~ Bayliss

19a. Informent's Name/Relationship (Type, Print): ~~PETER MINETREE~~ (SON) James Lawrence Minetree

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7513 CANDYTUFT CT. SPRINGFIELD,VA. 22153.

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY Date: 11/01/2001

20c. Location - City or Town, State: BALTO.,MD.

21. Signature of Funeral Service Licensee: William R. Lewis III

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 6500 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Strokes — 2yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2☒ **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: [signature] physician

29c. License number: D29769

29d. Date signed (Month, Day, Year): 10/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anna Lisa D. Albuerne 516 W. Rolling Rd Balto md 21228

State Registrar

31. Date filed (Month, Day, Year): NOV 0 6 2001

32. Registrar's Signature: Geneva D Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

// Rhoda B. Minetree

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM #23c PER PHY G801 11/20/01 JH

Reg. No. 2001 35326

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
EDWARD ALOYSIUS MOONEY	November 5, 2001	10:17AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Greater Baltimore Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-10-8262	XX 1☐M 2☐F	87 Yrs.			March 22, 1914	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Towson	1☐Yes 2☐No XXX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
20 Treeway Court #2B	21286	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married XX Married 3☐Widowed 4☐Divorced	XX Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Assistant Administrator	City of Baltimore

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Aloysius Mooney	Mary McNeal

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Virginia K Mooney Wife	20 Treeway Ct #2B Towson, Maryland 21286

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 XX Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Dulaney Valley	11/8/01	Timonium Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Dennis Stephen Kenakos	Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiopulmonary Arrest	30 min
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Respiratory Arrest	30 min
Due to (or as a consequence of):		
c.	~~Aspiration~~ AGONAL ASPIRATION	
Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4 X Unknown	1☐Yes 2 X No	1☐Yes 2 X No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2 X No	Hospital: 1☐Inpatient 2 X ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
MD	D27437	11/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN WOGAN MD 6701 North Charles Street Towson MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 6 2001	D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

mooney, Edward

#23c

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35327

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Julia Mae Murphy
2. Date of Death Month / Day / Year: October 31, 2001
3. Time of Death: 3:30 PM
4a. Facility Name *(If not institution, give street and number)*: Prince Georges Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-20-5746
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 25, 1910
9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Landover
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 912 Central Hills Lane
10f. Zip Code: 20785
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper
16b. Kind of Business/Industry: Private Residence

17. Father's Name *(First, Middle, Last)*: William Murphy
18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Lyles

19a. Informant's Name/Relationship *(Type, Print)*: Yvonne H. Johnson/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 912 Central Hills Lane Landover, MD 20785

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc.
Date: 11-2-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn P. McDonald
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION-RESPIRATORY FAILURE — < 2 days

Due to (or as a consequence of):
b. GASTRIC DYSMOTILITY — > 4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. LOWER G.I. BLEEDING

Due to (or as a consequence of):
d. DIVERTICULITIS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Bradycardia, Alzheimer's
S/p - Subtotal Colectomy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D-34525
29d. Date signed *(Month, Day, Year)*: 11-01-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S.J. RAO, MD; 4000 Mitchellville Road; #220; Bowie, MD 20716

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 06 2001
32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ADH
TIMOTHY MCCABE
01-6165-003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Timothy Joseph McCabe
2. Date of Death (Month, Day, Year): OCTOBER 31, 2001
3. Time of Death: 1345 P M
4a. Facility Name (If not institution, give street and number): 7957 BAY STREET
4b. City, Town, or Location of Death: PASADENA
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-86-9040
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 35 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 19, 1966
9. Birthplace (State or Foreign Country): Conn.

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7957 Bay Street
10f. Zip Code: 21122
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Vice president
16b. Kind of Business/Industry: McCabe & Associates

17. Father's Name (First, Middle, Last): Thomas Joseph McCabe
18. Mother's Neme (First, Middle, Maiden Surneme): Linda Szeliga

19a. Informant's Name/Relationship (Type, Print): Thomas & Linda McCabe-parents
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 900 Rocky Glen Drive, Brookville, Md. 20833

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): St. Louis Cemetery
Date: 11/05/2001
20c. Location - City or Town, State: Clarksville, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Witzke Funeral Homes, Inc 5555 Twin Knolls Road, Columbia, Md. 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart faifure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cutting wounds of NECK
Due to (or as a consequence of):
b.
Due lo (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at lime of deeth 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
B. pcam disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probebly 4 [ ] Unknown
24a. Was an eutopsy performed? 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Menner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 10/31/01
28b. Time of Injury: 1:30 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SUBJECT CUT SELF
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify): residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 7957 BAY STREET PASADENA, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es steted. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: OCME
29d. Date signed (Month, Day, Yeer): NOVEMBER 1, 2001
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 0 6 2001
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Ruth Elinor Meade	November 4 2001	5:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Agnes Hospital. 900 Caton Ave	Baltimore, MD 21229	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-26-9322	1☐M 2☒F	70 Yrs.			Dec., 17, 1930	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Catonsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
305 Orley Road	21228	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Elementary School Teacher	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Brant	Edna Callis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Meade - son	12449 Barnard Way, West Friendship, MD. 21794

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Dulaney Valley Mem. Grds	Nov. 08, 2001	Timonium, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Sandra L Lemmer	Witzke Funeral Home of Catonsville 1630 Edmondson Ave., Catonsville, MD. 21228

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Non-Hodgkin's Lymphoma	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A Tassi MD	D0056422	November 4th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Taher A Tassi, 900 Caton Ave, Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 6 2001	▶ Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME MEADE RUTH B

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35330

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Mellendick
2. Date of Death Month Day Year: November 3, 2001
3. Time of Death: 8:10 PM
4a. Facility Name *(If not institution, give street and number)*: Ridgeway Manor Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-03-7225
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/14/1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 2210 Rockwell Avenue
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Harry Pierson
18. Mother's Name *(First, Middle, Maiden Surname)*: Elma Floyd New

19a. Informant's Name/Relationship *(Type, Print)*: Joseph Mellendick, Jr. Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1622 Chesworth Road Catonsville, MD 21228

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: New Cathedral Cem.
Date: 11/06/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Edwin M. Perkins
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home 736 Edmondson Ave. Catonsville MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular ACCIDENT — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Edmund P. Klaisle
29c. License number: D34951
29d. Date signed *(Month, Day, Year)*: 11/05/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edmund P. Klaisle 405 Frederick Rd Suite 100 Catonsville MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 06 2001
32. Registrar's Signature: ▶ Geneva B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35331

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
STANLEY R. MILLER	OCT. 31 2001	11:35AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
20 Court Pleasant	Baltimore County	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (State or Foreign Country)
216-12-2546	1☐M 2☐F XX	79 Yrs.			Sept. 26, 1922	PA.

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore County	1☐Yes 2☒No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
20 Court Pleasant	21222	USA

11. Marital Stetus	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Detes:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	XXYes 2☐No WW 11	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12th grade	N/A	Security Guard	Security Industry

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Theodore Miller	Rose Unknown

19a. Informent's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
Mrs. Vicki L. Outten	20 Court Pleasant Dundalk, Md. 21222

20a. Method of Disposition	20b. Placa of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1☐Buriel 2☒Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)	Metro Crematory Inc.	11-1-01	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ William L. Clark	Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician Medical Examiner

23a. Part I. Enter the disease, or complications ther caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in death)	a. Metastatic Colon Cancer	1 year
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or es a consequenca of):	
	d. Due to (or es a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month / Dey / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24e. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end placa, and due to the cause(s) end manner es stated.
2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Charles Padgett MD	D15546	Oct 31, 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)
Charles Padgett MD, 5601 Loch Raven Blvd, Baltimore, MD 21239

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	▶ Benjamin F. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

STANLEY MILLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35332

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BETTY . F. MILLER
2. Date of Death Month Day Year: November 3, 2001
3. Time of Death: 8:20 AM
4a. Facility Name (If not institution, give street and number): 7529 HARFORD RD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 172-20-8093
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 17, 1925
9. Birthplace (State or Foreign Country): W.V.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 7529 HARFORD RD.
10f. Zip Code: 21234
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 7th
College (1-4or 5+): N/A
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BEAUTICIAN
18b. Kind of Business/Industry: SELF.

17. Father's Name (First, Middle, Last): BONNIE HERBERT BOSO
18. Mother's Name (First, Middle, Maiden Surname): FAYE CLOUSTON

19a. Informant's Name/Relationship (Type, Print): HARTLEY MILLER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7529 Harford RD, Balto. MD 21234

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAKLAWN Cemetery
Date: 11/7/01
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: ▶ Paul M. Stella
22. Name and Address of Facility: FUNERAL HOME CHD. HARTLEY Miller 7527 HARFORD RD. BALTO. MD 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Leukemia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Type 2 Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.
29b. Signature and title of certifier: ▶ David H Mradel MD, PhD
29c. License number: D31479
29d. Date signed (Month, Day, Year): 11/5/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID H MRADEL MD. 5600 Loch Raven BLVD. Balto. MD.

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: Bonnie D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Betty F Miller

RR

RR 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35333

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William M. Murphy
2. Date of Death Month: 11 Day: 03 Year: 2001
3. Time of Death: 12:55 AM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 220-32-5468
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 12, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 605 Prince George Street
10f. Zip Code: 20707
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supply Officer
16b. Kind of Business/Industry: United States Government

17. Father's Name (First, Middle, Last): Thomas M. Murphy
18. Mother's Name (First, Middle, Maiden Surname): Mary Regina Malone

19a. Informant's Name/Relationship (Type, Print): John B. Murphy /son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11707 Basswood Drive, Laurel, Maryland 20708

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ivy Hill Cemetery
Date: Nov 7,2001
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: [signature] M00773
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonia — Approximate Interval Between Onset and Death: Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. cerebrovascular accident — years
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: coronary artery disease

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D54853
29d. Date signed (Month, Day, Year): 11-03-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Danny Lee, MD. 8317 Cherry Ln, Laurel MD 20707

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RR

RR 2571

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDITEM #23a&b PER PHY G801 11/15/01 JH

Certificate of Death

Reg. No. 2001 35334

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Yaar	3. Tima of Death
Meryl Larue McKinley	November 4 2001	9:30 PM

4a. Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
Presbyterian Home of Maryland	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Yaar: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-52-8809	1☐ M 2☒ F	99 Yrs.			April 2, 1902	Maryland

Usual Rasidance of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Towson	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
400 Georgia Court	21204	United States

11. Marital Status	12. Was Dacadant Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - Amaricen Indian, Black, Whita, atc.
1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elamentary/Secondary (0-12)	Collega (1-4or 5+)		
8		Homemaker	Own Home

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
John Henry Marshall	Virginia Myers

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty M. Phoebus (Daughter)	2 Marathon Court, Apt. 1-A Catonsville, MD 21228

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cemetery, crematory or other place)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Lorraine Park Cemetery	11/8/01	Baltimore, Maryland

21. Signature of Funaral Sarvice Licensee: ▶ Steven T. Zittle

22. Nama and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximate Intarval Batween Onsat and Daath
Immediata Causa (Final disaasa or condition resulting in daath)	a. PYELONEPHRITIS ~~Urinary tract infection~~	2 weeks
	Dua to (or as a consaquanca of):	
Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaase or Injury that initiated evants resulting in death) Last	b. ALZHEIMER''S DISEASE	
	Dua to (or as a consequance of):	
	c.	
	Dua to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to complation of causa of daath?
1☐ Yas 2☒ No	1☐ Yas 2☒ No

25. Was cesa rafarred to medical examiner?	26. Placa of Death (Check only one)	
1☐ Yas 2☒ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the cause(s) and mannar stated.

29b. Signatura and titla of cartifiar	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶ Attending MD	D37016	November 5, 2001

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): Kenneth M. Greene, MD 6701 N. Charles St, Suite 410F Baltimore, MD 21204

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
NOV 06 2001	Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 5 PER FH G801 11/26/01 RR

Certificate of Death

Reg. No. 2001 35335

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): M.(ary) CLARE MAYNES MOORE

2. Date of Death (Month, Day, Year): October 31, 2001

3. Time of Death: 8:00 AM

4a. Facility Name (If not institution, give street and number): 4 A Honeybee Court

4b. City, Town, or Location of Death: Cockeysville

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 220-20-~~4652~~ 4657

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 5, 1927

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4 A Honeybee Court

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): English High Sch Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): George Arthur Maynes, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Regina Johanna Dumler

19a. Informant's Name/Relationship (Type, Print): (Son) Rev. Fr. Christopher P. Moore

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17630 Virginia Avenue, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem Grdns

Date: 11/5/2001

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon Carcinoma — 7 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year):

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Davis M Hahn MD

29c. License number: 020396

29d. Data signed (Month, Day, Year): November 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Davis Hahn, M.D., 5601 Loch Raven Blvd., Baltimore, Maryland 21239

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: Penny D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar 11-6-01 JAB AMND ITM#29c PR. DVR. G801

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35336

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Geovanny		Medina	April	09,	2001	5:41 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
NA	X 1 M 2 F	Yrs.				1	April 09,2001	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13531 Georgia Ave. #1	20906	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 X Yes 2 No Specify: Salvadorian	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		Infant	Infant

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
Luis	Alfredo	Medina	Alba	Dinora	Alvarenga

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alba D. Medina/Mother	13531 Georgia Ave., #1 Silver Spring, MD 20906

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Maryland National	April 13, 2001	Laurel, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Laura A. Moody	Rapp Funeral & Cremation Svc 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Extreme Prematurity	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnency 1 Live birth 2 Fetal death 3 Ectopic pregnency 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No 3 Probably 4 Unknown	1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yaer)
MD	P12530 ~~AH 2328195 JL 55~~	4/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Liao, M.D. 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 6 2001	Lenora G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

2001 35337

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Pattie Norwood			2. DATE OF DEATH (Month, Day, Year): Nov 02 2001	3. TIME OF DEATH: 8:25pm M
4. SOCIAL SECURITY NUMBER: 217-18-5959	5. SEX: 1 ☐ M X F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 07 15 09	8. BIRTHPLACE (State or Foreign Country): NC
9a. FACILITY NAME (If not institution, give street and number): Blue Point Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Balto MD 21215		9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: NA	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 2036 West Saratoga Street		10f. ZIP CODE: 21223	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4 or 5+): na	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Robert Boone		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mittie UNK	
19a. INFORMANT'S NAME (Type/Print): Lillie Norwood-Daughter	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2036 West Saratogo Street, Baltimore Md 21223		
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Meadow Ridge Cemetery	DATE: 11/8/01	20c. LOCATION — City or Town, State: Elkridge, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ruben E. Hoy	22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Ave, Baltimore Md 21215		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive heart failure exacerb. DUE TO (OR AS A CONSEQUENCE OF):	1wk
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. due to Pneumonia superimposed DUE TO (OR AS A CONSEQUENCE OF):	
	c. Renal failure DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN X

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Amatun H Naeem MD	29c. LICENSE NUMBER: D 15503	29d. DATE SIGNED (Month, Day, Year): ▶ Nov 05 2001
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AMATUN H NAEEM, 501 Dolphin St, Balto MD 21217		
31. DATE FILED (Month, Day, Year): NOV 0 6 2001	32. REGISTRAR'S SIGNATURE: Geneva D Sparks	

DHMH-16 Rev 1/89

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35338

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barbara F. Nelson
2. Date of Death: Month 10 Day 31 Year 01
3. Time of Death: 5 P.M.

4a Facility Name (If not institution, give street and number): Joseph Richie Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-36-1148
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/1/39
9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Md. | 10b. County: N/A | 10c. City, Town or Location: Baltimore | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1424 Stonewood Rd. | 10f. Zip Code: 21239 | 10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Baltimore City

17. Father's Name (First, Middle, Last): William Finney
18. Mother's Name (First, Middle, Maiden Surname): Fannie Finney

19a. Informant's Name/Relationship (Type, Print): Samuel Nelson Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3703 Callaway Ave, Baltimore, Md. 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Cem. | Date: 11/7/01
20c. Location - City or Town, State: 1 Owings Mills, Md.

21. Signature of Funeral Service Licensee: Lloyd M. Estep
22. Name and Address of Facility: Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Metastatic Leiomyosarcoma	2 yrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hosp & Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Iredell W. Iglehart III MD
29c. License number: D33400
29d. Date signed (Month, Day, Year): 10/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Iredell W. Iglehart III MD 500 W University Pkwy Baltimore MD 21210

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: Barbara B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

5:00pm 10/30/01 Barbara Nelson 10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35339

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
NAOMA		OLSZEWSKI	NOVEMBER 4, 2001	0935 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL CENTER	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-05-8486	1 ☐ M 2 ☒ F	85 Yrs.			8/17/1916	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Reisterstown	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
16 Brookebury Drive	21136	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Supervisor	Social Security

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Wilder	Elizabeth Schmidt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia Long - Daughter	127 Main St., Reisterstown, Md. 21136

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	St. Stanislaus Cem.	Nov. 8, 2001	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ H.J. Eckhardt	Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

b. _____

Due to (or as a consequence of):

c. _____

Due to (or as a consequence of):

d. _____

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month / Day / Year
1 ☐ Yes 2 ☐ No 9 ☒ Unknown	1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of deeth 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☒ Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred to medicat examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Michael Rothe MD	D43401	NOVEMBER 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ROTHE, MD 5401 OLD COURT ROAD RANDALLSTOWN, MARYLAND 21133

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	▶ Denise D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35340

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joe F. Pulliam, Jr.

2. Data of Death — Month: October; Day: 31; Year: 2001

3. Time of Death: 1333 PM

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-78-6756

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 40 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Year)*: 11-14-60

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedant

10a. State: MD

10b. County: Prince George

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11800 Beltsville Drive Apt.#104

10f. Zip Code: 20705

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 11th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Landscraping

17. Father's Name *(First, Middle, Last)*: Joe F. Pulliam, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Augusta Rice

19a. Informant's Name/Relationship *(Type, Print)*: Augusta Pulliam

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11800 Beltsville Dr. Apt.#104 Beltsville, MD 20705

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens

Data: 11-08-2001

20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: Gladys Warner

22. Name and Address of Facility: Baltimore, Maryland 21202 — March F.H., East 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — 10 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Aquired Immune Deficiency Syndrome — 3 days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Maino MD

29c. License number: MD 17643 5M13876

29d. Date signed *(Month, Day, Year)*: OCTOBER 31 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas J. Maino M.D. 201 East University Parkway, Baltimore MD 21218-2895

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 06 2001

32. Registrar's Signature: Benjamin D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

James Payne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James Thomas Payne	November 3, 2001	3:45 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Chesapeake Hospice House	Linthicum	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
535-16-2847	1 [X] M 2 [ ] F	78 Yrs.			SEPT 25, 1923	Washington

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Annapolis	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3161 Catrina Lane	21403	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Pharmacist	Pharmaceutical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Fred Charles Payne	Neoma Marion Mauget

19e. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janet Lynn Wilson/Daughter	3161 Catrina Lane Annapolis, MD 21403

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)	Metro Crematory Inc.	11-3-01	Baltimore, MD

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ Dawn F. McDonald Dawn F. McDonald	Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediete Cause (Finel diseese or condition resulting in death)	a. Prostate Cancer	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Last	b. Due to (or es a consequence of):	
	c. Due to (or as e consequence of):	
	d. Due to (or as a consequence of):	

RR

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Dale of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2 [ ] **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Sarah L Horton MD	D0057985	11/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sarah Horton 600 Ridgley Avenue Suite 231 Annapolis, MD 21401

RR 6

State Registrar

31. Dete filed (Month, Day, Yeer)	32. Registrar's Signature
NOV 0 6 2001	▶ Debra D Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Kenneth Parrish

2. Date of Death (Month, Day, Year): NOVEMBER 5, 2001

3. Time of Death: 3:30 AM

4e. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 223-22-1685

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 30, 1925

9. Birthplace (State or Foreign Country): Richmond, Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 732 Camberley Circle

10f. Zip Code: 21204

10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Jewelry

17. Father's Name (First, Middle, Last): Walter Cleveland Parrish

18. Mother's Name (First, Middle, Maiden Surname): Anne Elizabeth Parrish

19a. Informant's Name/Relationship (Type, Print): Mr. Chris T. Van Note (Step Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 732 Camberley Circle Towson, Maryland 21204

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville Veterans Cemetery

Date: 11/06/2001

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Adenocarcinoma of the lungs — > 4 wks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. C.A.D — > 5 years

Due to (or as a consequence of):

c. Hypertension — > 5 years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D42736

29d. Date signed (Month, Day, Year): 11-5-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 7600 Osler Drive - Suite 411 Towson Md 21204

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: Penny D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Parrish, William

RF

RA 5+1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Purcell
2. Date of Death Month Day Year: October 26 2001
3. Time of Death: 12:40 AM
4a. Facility Name (If not institution, give street and number): Harbor Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-56-4267
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 50 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 30, 1951
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: A.A.
10b. County: A.A.
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 5200 BALLMAN AVE.
10f. Zip Code: 21225
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: VIET.
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CAB DRIVER
18b. Kind of Business/Industry: TAXI

17. Father's Name (First, Middle, Last): ALVIN PURCELL
18. Mother's Name (First, Middle, Maiden Surname): HELEN CARMINE

19a. Informant's Name/Relationship (Type, Print): BONNIE GAVIGAN
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6700 RAPID WATERWAY GLEN BURNIE, MD. 21060

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory, other place): BAY VIEW CREMATORY
Date: OCT. 29 2001
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name and Address of Facility: SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cancer — Approximate Interval: 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: None

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Antoinette R. Roth
29c. License number: RES001
29d. Date signed (Month, Day, Year): October 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Antoinette Roth Harbor Hospital Center 3001 South Hanover Street. Baltimore, MD.

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35344

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DEBRA J. PERERA
2. Date of Death Month Day Year: November 3, 2001
3. Time of Death: 1640 M
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-60-2393
6. Sex: 1☐ M 2☒ F
7. Age (In yrs, last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 5, 1956
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1627 POPLAND
10f. Zip Code: 21226
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISABLED
18b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): JOHN J. SCARLETT
18. Mother's Name (First, Middle, Maiden Surname): DELORES WEST

19a. Informant's Name/Relationship (Type, Print): SHEREEN SHADLE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1627 POPLAND ST. BALTIMORE, MD. 21226

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BAYVIEW CREMATORY
Date: Nov. 7, 2001
20c. Location - City or Town, State: BALTIMORE MD

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name and Address of Facility: SKARDA F.H. 2829 HUDSON ST. BALTO., MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. pneumonia — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. human immunodeficiency virus — unknown
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D47353
29d. Date signed (Month, Day, Year): November 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JON FALCK MD St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Perera, Debra J

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

NAME
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35345

5:52 PM 11-1-01 Jean Parrish

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean Carol Parrish
2. Date of Death: Month NOV. Day 1, Year 2001
3. Time of Death: 5:52 PM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 161 30 6122
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 27.1937
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: Maryland
10b. County: Balto. Co.
10c. City, Town or Location: Cockeysville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 807 W. Padonia Road
10f. Zip Code: 21030
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Neme (First, Middle, Last): Charles W. Fink
18. Mother's Neme (First, Middle, Maiden Surneme): Ellen M. Kurtz

19a. Informent's Name/Reletionship (Type, Print): Scott Parrish (Husband)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 807 W Padonia Road, Cockeysville, MD 21030

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Baltimore-Washington
Dete: 11/3/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Walter Henss
22. Neme end Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, MD 21211

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediete Cause (Finel diseese or condition resulting in deeth)	a. lung cancer	years
	Due to (or es e consequenca of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditfone** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Menner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: Helen M Gordon
29c. License number: D0051926
29d. Date signed (Month, Day, Year): November 2, 2001

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Helen M. Gordon 6565 N. Charles St Baltimore MD 21204

State Registrar

31. Dete filed (Month, Day, Year): NOV 0 6 2001
32. Registrer's Signeture: Geneva D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-6256-510

MAYELIN PERAZA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 011502:ITEMS#1,23a,27 per ME G605 ss

Certificate of Death

Reg. No. 2001 35346

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mayelin Nicoll ~~Peraza~~ Perasa	NOVEMBER 5, 2001	12:05A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE	City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-61-6750	1☐ M 2☒ F	Yrs.	1	24			Sept. 10, 2001	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Owings Mills	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2 Trolod Court	21117	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☒ Yes 2☐ No Specify: El Salvadorian	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		None	---

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Julio Alberto Perasa	Iris Funes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Julio A. Perasa - Father	2 Trolod Ct. Apt. F Owings Mills, Md. 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removat from State 4☐ Donation 5☐ Other (Specify)	All Saints Cemetery	Nov. 6, 2001	Reisterstown, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ H. Eckhardt	Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE PNEUMONIA AND INTERSTITIAL PNEUMONITIS COMPLICATING LARYNGEAL EDEMA	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶	O.C.M.E.	NOVEMBER 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as tha burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	▶ Jennifer D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35347

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Yaar	3. Time of Death
Emma	Elizabeth	Rankin	October 26, 2001	02:55 am

4a. Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
GREATER BALTIMORE MEDICAL CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign Country)
NONE	1☐ M 2☒ F	0 Yrs.		10	October 25, 2001	Maryland

Usual Residenca of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	CARROLL	Woodbine	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6001 Davis Road	21797	USA

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☐ No If Yes, Give Year or Dates: N/A	1☐ Yes 2☐ No Specify: N/A	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
0		N/A	N/A

17. Fathar's Name (First, Middle, Last)	18. Mother's Name (First, Middla, Meiden Surnema)
Eugene Martin Rankin	Gretchen Altergodt

19a. Informant's Name/Relationship (Type, Print)	19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
NIKKI CHILCOAT (STAFF)	6701 N.CHARLES ST.,TOWSON,MARYLAND,21204

20a. Method of Disposition	20b. Placa of Disposition (Neme of cemetary, crematory or other placa)	Data	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GREEN MT.CREAMATORY	11-05-01	BALTO.,MD.,21202

21. Signatura of Funaral Service Licensae	22. Name and Address of Facility
▶ R. H. Lutts	HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disaase or condition resulting in death)	a. Extreme prematurity	10 hours
	Due to (or as a corisequence of):	
Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Wes an autopsy performed?	24b. Were autopsy findings evellable prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specity)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Virma V. Torres, MD	D20269	10-26-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Virma V. Torres, M.D. GBMC 6701 N. Charles St, Balto. MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Donald Roseboom mc Rossville Baltimo

Donald Roseboom 8:15AM October 29, 2001 Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35348

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD ROSEBOOM

2. Date of Death: Month OCT. Day 29 Year 2001

3. Time of Death: 8:15 AM.

4e. Facility Name (If not institution, give street and number): MANOR CARE ROSSVILLE

4b. City, Town, or Location of Death: ESSEX

4c. County of Death: BALTIMORE CO.

Funeral Director

5. Social Security Number: 355-14-5752

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 6, 1924

9. Birthplace (State or Foreign Country): ILL.

Usual Residence of Decedent

10a. State: MD. 10b. County: BALTIMORE 10c. City, Town or Location: ESSEX 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 6600 RIDGE RD. 10f. Zip Code: 21237 10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PLUMBER

16b. Kind of Business/Industry: PLUMING

17. Father's Name (First, Middle, Last): DONALD E. ROSEBOOM

18. Mother's Name (First, Middle, Maiden Surname): MARGAET ELLIOTT

19a. Informant's Name/Relationship (Type or Print): YOLAND DORSEY DEPT. OF AGING

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 611 CENTRAL AVE. TOWSON, MD.

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): BAYVIEW CREMATORY Date: OCT. 30 2001

20c. Location - City or Town, Stete: BALTO. MD.

21. Signature of Funeral Service Licensee: Thomas J. Sparks Jr.

22. Name end Address of Facility: SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. Prostate Cancer — 1 year.

Due to (or as a consequenca ol):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequenca ol):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Place ol Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time ol Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier:

29c. License number: D45475

29d. Date signed (Month, Day, Year): 10/29/01

30. Neme and address ol person who completed cause ol death (Item 23e) (Type, Print): Mohammed Rahnama 8100 Harford Road 21234

State Registrar

31. Dete tiled (Month, Day, Year): NOV 06 2001

32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35349

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Karl Reichlin

2. Data of Death Month Day Year: October 30, 2001

3. Tima of Death: 7:23 PM

4a. Facility Nama *(If not institution, giva street and number)*: Carroll Lutheran Village

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-01-0225

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 30, 1904

9. Birthplace *(State or Foreign Country)*: Switzerland

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 200 St. Luke's Lane

10f. Zip Code: 21158

10g. Citizen of What Country?: United States

11. Marital Stalus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Developer and Contractor

16b. Kind of Businass/Industry: Reichlin and Liebno Construction Company

17. Father's Nama *(First, Middle, Last)*: Anton Reichlin

18. Mother's Name *(First, Middle, Maiden Surname)*: Lydia Rebsemen

19a. Informant's Name/Ralationship *(Type, Print)*: Allen Reichlin Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24890 Pealiquor Road; Denton, Maryland 21629

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olive Cemetery | Date: 11/2/01

20c. Location - City or Town, Stata: Randallstown, Maryland

21. Signature of Funeral Service Licensee: [signature] M00869

22. Nama and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediata Causa (Final diseasa or condition rasulting in death)
a. Prostate Carcinoma, Metastatic — 3 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last
b.
Dua to (or as a consequence of):
c.
Dua lo (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa refarred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 8☒ Othar *(Specify)* Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: ▶ Daniel Alexander

29c. License number: D52815

29d. Data signed *(Month, Day, Year)*: 11/1/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Carroll Lutheran Village, 200 St. Luke's Circle; Westminster, Maryland 21158

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 0 6 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 35350

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES IGLEHART RANDALL

2. Date of Death Month Day Year: November 1, 2001

3. Time of Death: 6:35 P.M.

4a. Facility Name *(If not institution, give street end number)*: Pickersgill

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-09-4325

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 13, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 615 Chestnut Ave.

10f. Zip Code: 21204

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1941-46

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): ; College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrical Engineer

16b. Kind of Business/Industry: Ballistics

17. Fether's Neme *(First, Middle, Last)*: Watson Beale Randall

18. Mother's Name *(First, Middle, Meiden Surneme)*: Virginia Marshall Wilson

19a. Informent's Name/Relationship *(Type, Print)*: Anne Randall (daughter)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9601 Dallas Ave. Silver Spring, Maryland 20901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Green Mount Cemetery

Date: 11-7-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: George J. Fiemann

22. Name end Address of Feclity: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Coronary Artery disease — Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Aortic stenosis - status post Valve replacement

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigetion, in my opinion, death occurred at the time, dete end piece, end due to the ceuse(s) and manner stated.

29b. Signeture and titie of certifier: A. Anthony Riley, MD

29c. License number: D25205

29d. Date signed *(Month, Dey, Year)*: November 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St Balto. md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 06 2001

32. Registrar's Signature: D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35351

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CECIL SERIO

2. Date of Death: Month 11 Day 02 Year 01

3. Time of Death: 1250P

4a. Facility Name (If not institution, give street and number): St. Elizabeth's Nursing & Rehab. Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-12-2974

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 23, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 937 Grovehill Road

10f. Zip Code: 21227

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Flooring Contractor

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Frank A. Serio

18. Mother's Name (First, Middle, Maiden Surname): Rosaria Forte

19a. Informant's Name/Relationship (Type, Print): Peggy M. Serio/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 937 Grovehill Road Arbutus, MD 21227

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date: 11/3/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dementia, Alzheimers — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitas, Coronary artery disease Hypertension, Osteoporosis, metastatic Colon cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [ ] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B Lee physician

29c. License number: D-52544

29d. Date signed (Month, Day, Year): Nov 3, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Benjamin S. Lee, M.D. 700 Geiger Rd #204, Catonsville MD 21228

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: Brenda D Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 12

01-6127-510
crn
Donald B. Serio

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 111501:ITEMS#23a,27,28a-f per ME G801 ss

Certificate of Death

Reg. No. 2001 35352

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Donald B. Serio	October 30, 2001	6:01 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
609 S. Smallwood Street	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-62-9509	1☒ M 2☐ F	48 Yrs.			APR 17, 1953	Louisiana

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
609 S. Smallwood Street	21223	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1970-1972	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Fork Lift Operator	Warehouse

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Donald Eugene Serio	Betty Louise Korenth

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anthony Benjamin Serio/Brother	808 Cliffedge Road Pikesville, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metro Crematory Inc.	11-2-01	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Dawn F. McDonald	Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC INTOXICATION AND ETHANOL USE

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnent et time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown	1☒ Yes 2☐ No	1☒ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined	Found: 10-30-01	Found at: 5:50a M	1☐ Yes 2☒ No	Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Found at home	609 S. Smallwood St., Baltimore, Maryland

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	October 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary C. Apple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	▶ Penny D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Smuck
2. Date of Death: Month 11 Day 4 Year 2001
3. Time of Death: 1255 AM
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore,
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 217-12-6746
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/17/1921
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 118 B SOUTH AMITY STREET
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8TH GRADE
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
18b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): UNAVAILABLE RONEY
18. Mother's Name (First, Middle, Maiden Surname): UNAVAILABLE

19a. Informant's Name/Relationship (Type, Print): JUDY A. HEINZ DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7915 VERNON AVE. BALTIMORE, MD 21236

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY
Date: 11/7/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — 5 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequenca of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the causa of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: P12445
29d. Date signed (Month, Day, Year): 11/4/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOSEPH MARTINEZ, MD 225. GREENE STREET BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35354

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
VIRGINIA K. SEDDON	NOVEMBER 5, 2001	12:14 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
OAK CREST VILLAGE CARE CENTER	PARKVILLE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaer: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
248-07-0231	1☐ M 2☒ F	90 Yrs.			12/27/1910	SOUTH CAROLINA

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	BALTIMORE	PARKVILLE	1☐ Yas 2☒ No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8519 A OLD HARFORD ROAD	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - Amarican Indian, Black, Whita, atc.
1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: WHITE

15. Decedant's Education (Specify only highest grade completed)		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)	SECRETARY	STATE OF MARYLAND
	4 YEARS		

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
UNAVAILABLE	ESSIE C. KAY

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
FRANK R. SEDDON SON	6200 OLD HARFORD ROAD BALTIMORE, MD 21214

20a. Mathod of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Data	20c. Location - City or Town, State
1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	METRO CREMATORY, INC.	11/7/01	CATONSVILLE, MD

21. Signeture of Funeral Service Licensee	22. Nema and Address of Facility
▶ Heather N. Hays	THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Entar tha disease, or complicetions that caused tha daath. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina.

		Approximata Intarval Batween Onset and Death
Immediata Causa (Final disaasa or condition resulting in death)	a. Colon Cancer	2 years
	Dua to (or as a consequance of):	
Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disaase or Injury that initieted events resulting in death) Last	b.	
	Dua to (or as a consequance of):	
	c.	
	Dua to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

Emphysema

Hypothyroidism

Dementia

23b. Did tobacco uas contributa to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Ware autopsy findings eveilable prior to completion of causa of death?
1☐ Yas 2☒ No	1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar?	26. Placa of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Naturel 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be datarmined		M	1☐ Yes 2☐ No	
	28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician**: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar steted.

29b. Signatura and titla of cartifiar	29c. Licensa number	29d. Date signed (Month, Day, Year)
▶ William M. Russell	D30182	November 5 2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print) WILLIAM M. RUSSELL MD 8800 LAUTHER BLVD BALTIMORE MD

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
NOV 06 2001	▶ D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Nov. 5, 2001 12:14 PM

R Virginia K. Seddon

N

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35355

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dawn Evelyn Starkey

2. Data of Deeth — Month: NOVEMBER Dey: 3, Yeer: 2001

3. Tima of Death: 1600 PM

4e Facility Nema (If not Institution, giva street end number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-34-1186

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 64 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth (Month, Dey, Year): April 3, 1937

9. Birthplaca (Steta or Foreign Country): Maryland

Usual Residenca of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baldwin

10d. Inside City Limits: 1☐ Yas 2☒ No

10a. Street and Number: 13701 E. Devonfield Drive

10f. Zip Code: 21013

10g. Citizen of Whet Country?: USA

11. Marifal Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Ricen, atc.): 1☐ Yes 2☒ No Specify:

14. Raca - American Indien, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): n/a

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nema (First, Middla, Last): Lawrence Knoch

18. Mother's Neme (First, Middle, Meiden Surneme): Evelyn Chesser

19a. Informent's Name/Reletionship (Type, Print): Robert L. Starkey, Jr./Husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 13701 E. Devonfield Dr., Baldwin, Maryland 21013

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Dulaney Valley Mem. Grdns.

Date: 11/6/01

20c. Locetion - City or Town, State: Timonium, MD 21093

21. Signature of Funaral Service Licensee: Bryan W. Clary

22. Neme end Address of Facility: Lemmon Funeral Home, 10 W. Padonia road, Timonium, Maryland 21093

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel disaesa or condition resulting in death): e. METASTATIC LUNG CANCER — 3 MONTHS

Due to (or es e consequence of):

Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated avants resulting in deeth) Lest

b.

Due to (or as e consequenca of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death buf not resulting in the underlying cause given in Pert I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availabla prior fo completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medicat examiner? 1☐ Yes 2☐ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, death occurred et the fime, date end pleca, end due to the cause(s) end menner steted.

29b. Signature and title of certifier:

29c. License number: D 37254

29d. Data signed (Month, Dey, Year): 11/3/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): BOON P. LIM, M.D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Dete filed (Month, Dey, Year): NOV 0 6 2001

32. Registrer's Signature: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. # 2001 35356

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
John	W.	Saunders	10	31	01	8 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harorside HealthCare Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-05-9528	1[X] M 2[ ] F	82 Yrs.					5/25/19	Norfolk, Va.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Baltimore	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1620 Abbotston St.	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[ ] No If Yes, Give Year or Dates: 45-46	1[ ] Yes 2[X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Longshoremen	Steel Worker

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John W. Saunders Sr.	Maggie Taylor Saunders

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Corine Saunders Wife	1620 Abbotston St, Baltimore, Md.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Garrison Forest Cem.	11/8/01	Owings Mills, Md.

21. Signature of Funeral Service Licensee: Lloyd M. Estep

22. Name and Address of Facility: Estep Brothers Funeral SEr, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Congestive heart failure	years
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	Due to (or as e consequence of): b. ischemic cardiomyopathy	years
	Due to (or as e consequence of): c.	
	Due to (or as e consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown	1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[X] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Netural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D37573	November 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jef Zibell MD 25 Main St. Reisterstown MD 21136

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	Bruce B. Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Thomas

2. Date of Death (Month, Day, Year): October 9 2001

3. Time of Death: 15:55 M

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-26-4635

6. Sex: 1 ☐ M 2 ☑ F

7. Age (In yrs. (last birthday)): 69 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 24, 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 6225 York Rd. Apt E 303

10f. Zip Code: 21212

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cosmetologist

16b. Kind of Business/Industry: self-employed

17. Father's Name (First, Middle, Last): Haywood Walker

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Joseph Thomas - cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208: 4100 Windridge Rd. Pikesville, Maryland

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Moriah Cem. Date: 10/15

20c. Location - City or Town, State: Landsdowne, MD.

21. Signature of Funeral Service Licensee: Kevin Parker

22. Name and Address of Facility: Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Approximate Interval Between Onset and Death: 24 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnent in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: David N. Hager

29c. License number: RES000

29d. Date signed (Month, Day, Year): October 10, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): DAVID N. HAGER 600 North Wolfe Street Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: Jennie D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35358

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred V. Thompson

2. Date of Death: Month NOV Dey 1, Year 2001

3. Time of Death: 10:00pm

4a. Facility Name (If not institution, give street and number): Hammonds Lane Genesis Eldercare

4b. City, Town, or Location of Death: Brooklyn Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-09-6760

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG 10, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2212 Cedley Street

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Packer

16b. Kind of Business/Industry: Glass Factory

17. Father's Name (First, Middle, Last): Unk.

18. Mother's Name (First, Middle, Maiden Surname): Blanch Franklin

19a. Informant's Name/Relationship (Type, Print): Frederick Fairchild/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 125 S. Schroeder Street Baltimore, MD 21223

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date: 11/3/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe Peripheral Vascular Disease with gangrene l/w/c

Due to (or as a consequence of):

b. Carcinoma of Uterus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Non Insulin dependent Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D30641

29d. Date signed (Month, Day, Year): November 2 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ramesh Sabapathi 201-109 Back River Neck Road Baltimore MD 21221

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

RR

RR 4

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35359

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mable J. Tracy	November 4 2001	1:11 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8415 Bellona ave. #715	Ruxton	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-14-1026	1☐M 2☒F	76 Yrs.			July 12 1925	Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Ruxton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8415 Bellona Ave. #715	21204	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Partner	Advertising

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Homer Jones	Bessie Ball

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Mr. Charles Tracy/ Husband	8415 Bellona Ave. #715 Ruxton, Md. 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Dulaney Valley Mem.	11-8-01	Timonium, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Breast CA	2 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetat deeth 3☐Ectopic pregnancy 4☐Pregnant at time ot death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contnbuting to death but not resulting in the underlying cause given in Part I.

Alzheimers Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D33624	11-5-01

30. Name and address of person who completed cause of death (Item 23a) (Type. Print): John G. Downs MD Oncology PA 7505 Osler Drive #302 Towson MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 6 2001	Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35360

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
LEROY	TURNER		October 31 2001	7:59p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. JOSEPH MEDICAL CENTER-ER	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-22-9441	1☒M 2☐F	73 Yrs.			MAY 30 1928	VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2577 EDMONDSON AVENUE	21223	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 46/49	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12yrs	2yrs	STEEL WORKER	BETH STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
EPHRAIM TURNER	BERTHA TURNER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sandy Wicks/Daughter	5702 Leiden Rd., Baltimore, Maryland 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GARRISON FOREST	11-7-01	OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Charles M Cornell	WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute bacterial endocarditis	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

mitral insufficiency

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Marc Sokolow Attending Physician	D26534	11/02/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Marc Sokolow, M.D 301 St. Paul Place Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 0 6 2001	D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

LEROY TURNER

#64

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 35361

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD WIENEKE
2. Data of Death Month / Day / Yaar: NOVEMBER 4 2001
3. Time of Death: 02:35
4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS BAYVIEW MED CTR
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 213-30-5020
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 68 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaer)*: July 17, 1933
9. Birthplaca *(State or Foraign Country)*: Maryland

Usual Rasidanca of Decedant

10a. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 7803 St. Bridget Lane
10f. Zip Coda: 21222
10g. Citizan of What Country?: United States

11. Marital Stafus: 1☐ Nevar Married 2☒ Married 3☐ Widowad 4☐ Divorced
12. Was Dacedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Giva Yaar or Datas: 1951-1955
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, afc.): 1☐ Yas 2☒ No *Specify:*
14. Raca - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 12 years; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Crane Foreman
16b. Kind of Businass/Industry: Steel

17. Fathar's Nama *(First, Middla, Last)*: Harry Wieneke
18. Mothar's Nema *(First, Middla, Meidan Surneme)*: Augusta Waldner

19a. Informant's Name/Ralationship *(Type, Print)*: Patricia Wieneke (Wife)
19b. Mailing Addrass *(Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 7803 St. Bridget Lane Dundalk, Maryland 21222

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar placa)*: Holly Hill Mem. Gardens
Data: 11/7/01
20c. Location - City or Town, Stata: Middle River, Md.

21. Signature of Funeral Service Licensee ▶ Charles Fuld
22. Nama and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)
a. ISCHEMIC CARDIOMYOPATHY — YEARS
Dua to (or as a consaquance of):
Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseese or injury that initiated avants resulting in daath) Last
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.
SUBDURAL HEMATOMA
HERPES ENCEPHALITIS
ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical exeminer? 1☐ Yas 2☒ No
26. Place of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar *(Specify)*

27. Mennar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined
28a. Date of Injury *(Month, Dey Year)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29e. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at the time, data and placa, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, date and placa, and due to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar ▶ Amy Freedman MD
29c. Licansa number: RES-000
29d. Data signed *(Month, Day, Year)*: NOVEMBER 4, 2001

30. Nama and address of person who complatad causa of daath (Item 23a) (Type, Print): AMY FREEDMAN, MD 4940 EASTERN AVE. BALTIMORE, MD 21224

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 06 2001
32. Registrar's Signatura ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

8

12+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35362

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald A. White

2. Date of Death Month Day Year: November 1 2001

3. Time of Death: 1:15 P.M.

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 157-30-8541

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 7, 1940

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4638 Mountain Road

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Retail Sales

17. Father's Name (First, Middle, Last): Earl White

18. Mother's Name (First, Middle, Maiden Surname): Mildred Kircher

19a. Informant's Name/Relationship (Type, Print): Arthur J. White (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4638 Mountain Road, Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. Date: Nov. 5, 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if eny, laeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. MUCUS PLUGGING

Due to (or as a consequence of):

c. PARAPLEGIA

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent et time of deeth 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D43977

29d. Date signed (Month, Day, Year): November 1 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 301 [illegible] Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

White Donald

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35363

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HILDEGARD WIRTZ
2. Date of Death Month Day Year: OCTOBER 31, 2001
3. Time of Death: 14:53 M
4a. Facility Name (If not institution, give street and number): UPPER CHESAPEAKE M.C.
4b. City, Town, or Location of Death: BELAIR
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 577-90-7189
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 24, 1920
9. Birthplace (State or Foreign Country): GERMANY

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 600 LIGHT ST. APT. 631
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): FRIEDERICH LEHWARD
18. Mother's Name (First, Middle, Maiden Surname): AUGUSTE HERTZFELD

19a. Informant's Name/Relationship (Type, Print): URSULA K. JACOB
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 OLD SOUND RD. JOPPA, MD. 21085

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SOUTHERN MEM GARDENS
Date: NOV. 5, 2001
20c. Location - City or Town, State: CALVERT CO. MD.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name and Address of Facility: HOFFMANN-SKARDA F.H. 3218 HUDSON ST. BALTO., MD. 21224

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. SEVERE METABOLIC ACIDOSIS — Approximate Interval Between Onset and Death: 3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. MENINGITIS — Due to (or as a consequence of): — 3 DAYS
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0053548
29d. Date signed (Month, Day, Year): OCTOBER 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFFREY A. THOMPSON MD 2003 FLORIBUNDA CT. FALLSTON, MD 21047

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: Gwen D Hoaks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HILDEGARD WIRTZ 2

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35364

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Waicker
2. Date of Death: Month / Day / Year: 11/01/2001
3. Time of Death: 7:35 PM
4a. Facility Name (If not institution, give street and number): 2905 Brockton Drive
4b. City, Town, or Location of Death: Kingsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-20-6259
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5/21/1926
9. Birthplace (State or Foreign Country): Baltimore, MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Kingsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2905 Brockton Drive
10f. Zip Code: 21087
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Building Manager
16b. Kind of Business/Industry: Baltimore Gas & Electric Co.

17. Father's Name (First, Middle, Last): George Waicker
18. Mother's Name (First, Middle, Maiden Surname): Barbara Gloss

19a. Informant's Name/Relationship (Type, Print): Ruth Waicker-wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2905 Brockton Drive Kingsville, Md 21087

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Highview Memorial Gardens
Date: 11/5/2001
20c. Location - City or Town, State: Fallston, Md

21. Signature of Funeral Service Licensee: E.F. Lassahn
22. Name and Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Rd Kingsville, Md 21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. NON-HODGKINS LYMPHOMA — 3MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Nowakowski MD
29c. License number: D08096
29d. Date signed (Month, Day, Year): NOVEMBER 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW NOWAKOWSKI MD 125 N. MAIN ST BEL AIR, MD 21014

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: Penelope B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35365

AMENDED ITEM#8 per inf G801 111601 ss

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MELVIN FREDERICK WALLACE

2. Date of Death: Month 10 Day 30 Year 01

3. Time of Death: 7:55 p.m.

4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 217-01-9849

6. Sex: 1 [X] M 2 [ ] F

7. Age *(in yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 3-9-1919 (March 7, 1919)

9. Birthplace *(State or Foreign Country)*: Balto. MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Ocean Pines

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 174 Windjammer Road

10f. Zip Code: 21181

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Bleck, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 4+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: President-Savings Bank

16b. Kind of Business/Industry: Banking

17. Father's Name *(First, Middle, Last)*: Frederick Wallace

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Zulauf

19a. Informant's Neme/Relationship *(Type, Print)*: David F. Wallace - son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 307 Amherst Ct. Bel Air, MD 21014

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or othar pleca)*: Lorraine Park Cem.

Date: 11/3/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensaa: John D. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, MD 21212

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. GI Bleed

Dua to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseasa or injury that initiated avants resulting in deeth) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: senile dementia

23b. Did tobacco use contribute to the causs of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner es steted. 2 [ ] **Medical Examiner**: On tha basis of axemination end/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) end manner stated.

29b. Signatura and title of certifier: physician

29c. License number: H44283

29d. Date signed *(Month, Day, Year)*: 10/30/01

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): Robert Duck 9733 Healthway Drive Berlin, MD

State Registrar

31. Date filed *(Month, Dey, Year)*: NOV 0 6 2001

32. Registrar's Signature: Geneva D Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wallace, Melvin

SS# 217-01-9849

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35366

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: QUEEN E. WEBB
2. Date of Death Month Dey Year: NOVEMBER 4, 2001
3. Time of Death: 11:45 AM
4a. Facility Name *(If not institution, give street and number)*: CATONSVILLE COMMONS NURSING CENTER
4b. City, Town, or Location of Death: CATONSVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-56-5432
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCTOBER 12, 1932
9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. Stete: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 513 THORNFIELD ROAD
10f. Zip Code: 21229
10g. Citizen of Whet Country?: USA
11. Meritel Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* AFRICAN AMERICAN
15. Decedent's Education *(Specify only highest grade completed)*: Elemantery/Secondary (0-12): 9th — College (1-4or 5+): 0
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HEALTH CARE PROVIDER
16b. Kind of Business/Industry: NURSING HOME
17. Father's Neme *(First, Middle, Last)*: MAN PATTERSON
18. Mother's Name *(First, Middle, Maiden Surnama)*: PEARL A. WEBB
19a. Informant's Name/Reletionship *(Type, Print)*: PEARL M. JENNINGS (DAUGHTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 513 THORNFIELD ROAD BALTIMORE, MD 21229
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. ZION CEMETERY — Dete: 11/08/01
20c. Location - City or Town, Stete: LANSDOWNE, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Fecility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on aach line. — Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in deeth) e. Cerebrovescular Accident — years

Due to (or as e consequence of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Wara eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death *(Chack only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, fectory, office building, etc. *(Specify)*
28f. Location *(Straat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daeth occurred et the tima, data end place, end due to tha causa(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, deeth occurred at tha time, data end placa, and dua to tha cause(s) end menner steted.

29b. Signeture end title of certifier: [signature] MDchaney MD
29c. License number: D-40524
29d. Date signed *(Month, Day, Year)*: November 5, 2001

30. Neme and address of person who completed cause of daeth (Item 23a) (Type, Print): DR. OCHANEJ 3350 WILKENS AVENUE SUITE 302 BALTIMORE, MD 21229

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 06 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
CATHERINE MARIE YOUNG	October 31,2001	8:05PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris Hospice	Timonium	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-34-4424	1☐M 2☒F XX	94 Yrs.					March 12,1907	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Timonium	1☐Yes 2☒No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2300 Dulaney Valley Road	21093	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒XWidowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes ☒XNo Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
9		Secretary	Parochial School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Clement Louis Klug	Catherine Campbell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anne L. Stiff DTR	1132 Cowpens Avenue Towson, Maryland 21286

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒XBurial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	New Cathedral Cem	11/5/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dennis Stephen Kenakes

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mark A Stromberg MD	D31543	November 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark Stromberg MD 6701 North Charles Street Towson, Maryland 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35368

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JESSE LEON AULT SR.	OCTOBER 13, 2001	4:05 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-48-3913	1 [X] M 2 [ ] F	55 Yrs.			December 25, 1945	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Frederick	Brunswick	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
511 West Potomac Street	21716	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Custodian	School System

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George William Ault	Ruth Isabella Myers

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Ault - Wife	511 West Potomac St. - Brunswick, MD 21716

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Brownsville Heights Cem.	10/16/2001	Brownsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert L. Spencer	Eackles-Spencer Funeral Home Harpers Ferry, WV 25425

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDIAL ISchemia	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Pulmonary hemorrhage	hours
	Due to (or as a consequence of): c. metastatic Lung Cancer	months
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A.Z. HEGAZI, MD	D44164	10-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A.Z. HEGAZI, MD 801 TOLLhouse Ave, Bldg F, Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 15 2001	▶ Denise D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35369

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Lee Baker

2. Date of Death (Month, Day, Year): October 13, 2001

3. Time of Death: 10:46 P.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-36-3067

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 25, 1939

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 6802 Amelano Drive

10f. Zip Code: 21702

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): LeRoy S. Baker

18. Mother's Name (First, Middle, Maiden Surname): Hannah Grove

19a. Informant's Name/Relationship (Type, Print): Omie Reeves Baker/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6802 Amelano Drive, Frederick, MD 21702

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): Harmony Church of the Brethren Cemetery | Dete: Oct. 18, 2001

20c. Location - City or Town, State: Myersville, MD

21. Signature of Funeral Service Licensee: Richard C. Basford M00021

22. Name and Address of Facility: Keeney & Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)
a. Coronary Artery disease — YEARS

Due to (or as a consequence of):
b. Diabetes — YEARS

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last
Due to (or as a consequence of):
c. Hypertension — YEARS

Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cauee ot death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Deeth (Check only one): Hospitel: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, In my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Sherman Kahan

29c. License number: D0012697

29d. Date signed (Month, Day, Year): 10-16-01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Sherman Kahan, MD. 915 Toll House Ave. Frederick, MD 21701

3

State Registrar

31. Date filed (Month, Day, Year): OCT 17 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35370

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Laura Knouse Bohrer	October 13, 2001	6:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
26767 Howard Chapel Drive	Damascus	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-88-6062	1☐M 2☒F	37 Yrs.			June 28, 1964	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Damascus	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
26767 Howard Chapel Drive	20872	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Police Officier	Montgomery County Maryland

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Knouse	Eileen Lafferty

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Christopher Bohrer - Husband	26767 Howard Chapel Drive, Damascus, Maryland 20872

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Gate of Heaven Cemetery	10/17/01	Silver Spring, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert L. Williams	Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lymphoma	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Joseph M. Haggerty MD	D32407	October 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Haggerty, M.D. 9707 Medical Center Drive, #300, Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 18 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35371

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
GEORGE	KENNETH	BACHMAN	OCTOBER	14	2001	12;50p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-05-8970	1☒M 2☐F	91 Yrs.			Jan. 30, 1910	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Thurmont	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7645 Black Road	21788	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Police Officer	Law Enforcement

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Theodore G. Bachman	Sophia B. Schling

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Virginia L. Bachman / Wife	7645 Black Road Thurmont, Maryland 21788

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Hagerstown Crematory	October 16, 2001	Hagerstown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Stauffer Funeral Homes, P.A. 104 E. Main Street Thurmont, Maryland 21788

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finel disease or condition resulting in death)	a. End-stage Interstitial fibrosis	5yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. Due to (or es a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Data of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Hypertension, Left CVA 7/23/01

23e. Did tobecco use contribute to the cause of death?	24e. Was en eutopsy performed?	24b. Were eutopsy findings availeble prior to completion of cause of deeth?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end menner as steted.
2☐**Medical Examinar:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ [signature] MD	D21944	10/15/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

James S. Grisson MD 300 W 9th St FREDERICK, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	[signature] B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35372

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hilda Jean Blair
2. Date of Death (Month, Day, Year): October 14, 2001
3. Time of Death: 6:00 PM
4a. Facility Name (If not institution, give street and number): 804 Montclaire Avenue
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 239-36-8078
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 7, 1927
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 804 Montclaire Avenue
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Admitting
16b. Kind of Business/Industry: Health Care Facility

17. Father's Name (First, Middle, Last): Ralph James Rasberry
18. Mother's Name (First, Middle, Maiden Surname): Vera Mae Maultsby

19a. Informant's Name/Relationship (Type, Print): Mr. William Otey Blair/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 804 Montclaire Avenue, Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Olivet Cemetey | Date: Oct 19, 2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Keith Lynn Peterson M00706
22. Name and Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. alzheimers — Due to (or as a consequence of): — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ted Adkins
29c. License number: D 27104
29d. Date signed (Month, Day, Year): October 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lloyd Hallowell MD 1475 Taney Ave, Frederick Md 21701

State Registrar

31. Date filed (Month, Day, Year): OCT 18 2001
32. Registrar's Signature: Bonnie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35373

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Frances Berry
2. Date of Death: Month October Day 20, Year 2001
3. Time of Death: 7:17 A M
4a. Facility Name (If not institution, give street and number): Edenton Garden House
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-42-8381
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 13, 1915
9. Birthplace (State or Foreign Country): Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Thurmont
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 8520 Hunt Club Road
10f. Zip Code: 21788
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Vito DeSilippo
18. Mother's Name (First, Middle, Maiden Surname): Rosa Chimiente

19a. Informant's Name/Relationship (Type, Print): Frances Berry / Daughter-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8520 Hunt Club Rd. Thurmont, MD 21788

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Crematory
Date: 10/22/01
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Stef B
22. Name and Address of Facility: Resthaven Funeral Services, Skkot Cody PA 9501 US Rt. 15 N, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial infarction	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	coronary artery disease	years
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
cerebral vascular disease
atrial fibrillation

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Lloyd Halverson MD
29c. License number: D22101
29d. Date signed (Month, Day, Year): 10/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lloyd Halverson, M.D. 1475 Taney Ave, Suite 204, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35374

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN KATHRYN BRUCHEY
2. Date of Death (Month, Day, Year): OCTOBER 21, 2001
3. Time of Death: 11:05 AM
4a. Facility Name *(If not institution, give street and number)*: RAVENWOOD LUTHERAN VILLAGE
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 217-32-7499
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 12, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1183 Luther Drive
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Edward Bentz
18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Mae Wachter

19a. Informant's Name/Relationship *(Type, Print)*: James E. Bruchey/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18 Stanford Road, Hagerstown, Maryland, 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery — Date: 10/25/2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ P. Ryan McMillion MO1202
22. Name and Address of Facility: Keeney and Basford Funeral Home, 106 East Chucrh Street, Frederick, Maryland, 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. — Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intestinal Obstruction. — 4days.
Due to (or as a consequenca of):
b. Colon CARCINOMA — 5years.

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Residenca 6☐ Othar *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Maryan Gray
29c. License number: D28365
29d. Date signed *(Month, Dey, Year)*: 10-21-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 368 Mill Street - Hagerstown MD 21742.

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 24 2001
32. Registrar's Signature: ▶ G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

BRUCHEY, HELEN KATHYRN

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Charles Walter Beaver	October 24 2001	1:10a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2500 Waterside Drive Suite 217	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-20-0315	1☒M 2☐F	79 Yrs.			Feb. 19, 1922	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2500 Waterside Drive Suite 217	21701	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Salesman	Auto

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
Paul Beaver Sr.	Catherine Elizabeth Slorp

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty Jane Beaver/ Wife	2500 Waterside Drive, Suite 217, Frederick Md 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removel from State 4☐Donetion 5☐Other (Specify)	Crestlawn Memorial Gardens / Oct. 27, 2001	Marriottsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Todd O Wyatt	Olin L. Molesworth P. A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. liver failure — Approximate Interval: 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. pancreatic cancer, metastatic — Approximate Interval: 2 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☑Unknown

24e. Was en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury el Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner es steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my oplnion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Katherine Buki, MD	D0054705	October 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Katherine Buki M.D. 300 West 9th Street, Frederick, Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 26 2001	▶ Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35376

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Isaac Buckler, Sr.
2. Data of Death Month Day Year: October 14, 2001
3. Time of Death: 4:15 PM
4a. Facility Name *(If not institution, give street and number)*: 36856 Dannys Lane
4b. City, Town, or Location of Death: Chaptico
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 218-30-3264
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: April 29, 1931
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. Stata: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Chaptico
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 36856 Dannys Lane
10f. Zip Coda: 20621
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Raca - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 6th grade; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Farmer
16b. Kind of Business/Industry: Own Farm

17. Fathar's Nama *(First, Middla, Last)*: James Parren Buckler
18. Mother's Name *(First, Middle, Maiden Surnama)*: Blanch L. Goldsmith

19a. Informant's Name/Relationship *(Type, Print)*: Florence G. Buckle (Wife)
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 36856 Dannys Lane, Chaptico, Maryland 20621

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cametery, crematory or othar place)*: Sacred Heart Cemetery — Data: 10/19/2001
20c. Location - City or Town, Stata: Bushwood, Maryland

21. Signature of Funeral Service Licensee: Mary Rizzo — Mary Rizzo MO1114
22. Nama and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only one ceusa on aach line.

Approximate Intarval Batween Onset and Death

Immediate Causa (Final disaasa or condition resulting in daath)
a. Small cell carcinoma — Sept 2000
Due to (or as a consequence of):
b. of Lung
Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disaasa or Injury that initiated events rasulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or as a consequance of):
d.

Part II. **Other signifkant conditions** contributing to death but not resulting in tha undarlying cause given in Part I.: COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa ratarred to medical examinar? 1☐ Yes 2☒ No
26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Rasidence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, tarm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician**: To the bast of my knowledga, daath occurrad at the tima, data and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signatura and titla of cartifiar: KOMERA
29c. License numbar: D36206
29d. Data signed *(Month, Day, Year)*: 10/17/01

30. Name and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): KIRAN MEHTA MD HOLLYWOOD MD 20636

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001
32. Registrar's Signatura: Bonnie G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35377

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Genevieve Elizabeth Brown
2. Date of Death (Month, Day, Year): October 17, 2001
3. Time of Death: 6:16 AM
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Nursing Center
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 577-46-8078
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 17, 1910
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 20711 Poplar Ridge Road
10f. Zip Code: 20653
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nanny
16b. Kind of Business/Industry: Child Care

17. Father's Name *(First, Middle, Last)*: Thomas Theodore Hayden
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Elizabeth Tippett

19a. Informant's Name/Relationship *(Type, Print)*: Helen Grinder (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20711 Poplar Ridge Road, Lexington Park, MD 20653

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Face Cemetery — Date: 10/20/01
20c. Location - City or Town, State: Great Mills, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtwon, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Cardiopulmonary Failure — Due to (or as a consequence of): — Day
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last:
b. Dehydration — Due to (or as a consequence of): — Days
c. Urosepsis — Due to (or as a consequence of): — mos
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Patrick Jarboe M.D.
29c. License number: D 06419
29d. Date signed *(Month, Day, Year)*: 10/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Patrick Jarboe, M.D. Hollywood, Maryland 20636

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001
32. Registrar's Signature: S. Smith

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(3)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35378

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Henry Bush, Sr.

2. Date of Death (Month, Day, Year): October 15, 2001

3. Time of Death: 6:09 AM

4a. Facility Name *(If not institution, give street and number)*: 28805 Braxton Way

4b. City, Town, or Location of Death: Mechanicsville

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 220-16-8996

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 26, 1921

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 28805 Braxton Way

10f. Zip Code: 20659

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator

16b. Kind of Business/Industry: Service Station

17. Father's Name *(First, Middle, Last)*: Arthur E. Bush

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Alice Thomas

19a. Informant's Name/Relationship *(Type, Print)*: Christine Bush Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 28805 Braxton Way Mechanicsville MD 20659

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Queen of Peace Cemetery

Date: 10/19/01

20c. Location - City or Town, State: Helen, Maryland

21. Signature of Funeral Service Licensee: [signature] 10/20/06

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D13072

29d. Date signed *(Month, Day, Year)*: 10/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gurbux Nachnani 8926 Woodyard Rd. Clinton MD 20735

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35379

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Herbert Buchanan
2. Date of Death (Month, Day, Year): October 12 2001
3. Time of Death: 1;50 A M
4a. Facility Name (If not institution, give street and number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 217-03-5222
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 19, 1910
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 43241 St. Andrews Church Road
10f. Zip Code: 20650
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Frank Buchanan
18. Mother's Name (First, Middle, Maiden Surname): Julia Sherkiff

19a. Informant's Name/Relationship (Type, Print): Della L. Buchanan Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 43241 St. Andrews Church Road Leonardtown MD 20650

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Charles Memorial Gardens
Date: 10/15/01
20c. Location - City or Town, State: Leonardtown Maryland

21. Signature of Funeral Service Licensee: Michael K Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. Po Box 270 Leonardtown MD 20650

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular disease — Y 25

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William Boyd MD
29c. License number: D14285
29d. Date signed (Month, Day, Year): 10-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM BOYD II M.D. P.O.BOX1753 LEONARDTOWN,MD.20650

State Registrar

31. Date filed (Month, Day, Year): OCT 15 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JOSEPH HERBERT BUCHANAN
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Irvin	Aloysius	Buckler	October 09, 2001	2:45am M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-36-9804	1☒M 2☐F	92 Yrs.			Oct. 1, 1909	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Leonardtown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
22680 Cedar Lane Road	20650	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th grade		Shipping Clerk	Civil Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Benjamin Buckler	Mary Addie Longmore

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Noreen M. Neel (Daughter)	P.O. Box 192, Piney Point, Maryland 20674

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Aloysius	10/12/2001	Leonardtown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Mary Rizzo MO1114	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	2 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. RENAL FAILURE	7 days
	Due to (or as a consequence of): c. DEHYDRATION	7 days
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

FAILURE TO THRIVE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D56096	10/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Rajbinder Gill Hollywood, Md. 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 10 2001	▶

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Irvin Aloysius Buckler

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#23a perPHYG801 11/06/01 EW

Certificate of Death

Reg. No. 2001 35381

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET Ann BROWN

2. Date of Death: Month OCTOBER Day 9 Year 2001

3. Time of Death: 0920

4a. Facility Name (If not institution, give street and number): Laurelwood Nursing Center

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 148-20-7311

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Jan. 13, 1928

9. Birthplace (State or Foreign Country): New Jersey

Usual Residance of Decedant

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Perryville

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 624 Richmond Street

10f. Zip Code: 21903

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - Amarican Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementery/Secondary (0-12): Eleven Years; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Telephone Operator

16b. Kind of Business/Industry: Museum of Natural History New York, New York

17. Father's Nama (First, Middle, Last): Joseph Patrick Murphy

18. Mothar's Name (First, Middle, Maidan Sumama): Ann Cohen

19a. Intormant's Name/Ralationship (Type, Print): Arthur C. Brown (husband)

19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code): 624 Richmond Street, Perryville, Maryland 21903

20a. Mathod ot Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Placa ot Disposition (Nama of cematary, cramatory or othar placa): R.A. Ferris & Co., Inc.

Data: 10/11/01

20c. Location - City or Town, State: West Chester, Pennsylvania

21. Signatura of Funeral Service Licensee: Thomas M. Patterson, Sr.

22. Nama and Address ot Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused tha deeth. Do not entar tha moda of dying, such es cardiac or respiratory errest, shock, or haart tailura. List *only ona* causa *on* aach lina.

Approximete Intervel Between Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death):
a. RENAL FAILURE
Due to (or as a consequance ot):
b. NIDDM

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaese or injury that initiated evants rasulting in death) Last:
Due to (or as a consequanca ot):
c. SUBDURAL HEMATOMA
Due to (or as a consequanca ot):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

~~SUB DURAL HEMATOMA~~

~~NIDDM~~

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to complation ot cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Placa ot Daath (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Dete ot Injury (Month, Day Year)

28b. Tima ot Injury

28c. Injury at Work? 1☐ Yas 2☒ No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, tarm, straat, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best ot my knowledge, death occurred at tha tima, data and placa, and due to tha causa(s) and mannar es steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred et tha tima, data and placa, and due to the ceuse(s) and mannar stated.

29b. Signeture end title of certifier: Arlen Stone, MD

29c. Licensa number: D50743

29d. Data signed (Month, Day, Year): OCTOBER 11 2001

30. Neme and address ot person who completed causa of death (Item 23a) (Type, Print): Arlen Stone, MD

State Registrar

31. Data filed (Month, Day, Year): OCT 11 2001

32. Registrar's Signature: [signature] P. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

23a
Cec. / 4734

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35382

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret C. Brown

2. Date of Death: Month: Oct; Day: 19; Year: 2001

3. Time of Death: 7:05 am

4a. Facility Name (If not institution, give street and number): 1340 Pleasant Valley Road

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-20-4300

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): Jan 4 1912

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Pleasant Valley

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1340 Pleasant Valley Road

10f. Zip Code: 21158

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Retail

17. Father's Neme (First, Middle, Last): Edward Wantz

18. Mother's Name (First, Middle, Maiden Sumame): Noami Myers

19a. Informant's Neme/Relationship (Type, Print): Catherine Schaeffer/daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 521 Dutrow Road Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Pleasant Valley Cem

Date: 10/22/2001

20c. Location - City or Town, Stete: Pleasant Valley, MD

21. Signature of Funeral Service Licensee: R. [illegible]

22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras thet the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit.

CARROLL #234

WJL 10

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)

a. organic brain syndrome — 5 years

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or es e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) end menner es stated.

2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: Paul E Forest MD

29c. License number: D33281

29d. Date signed (Month, Dey, Year): 10/19/01

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): 912 Washington Road, Westminster, MD. 21157 PAUL E FOREST, M.D.

State Registrar

31. Dete filed (Month, Dey, Year): OCT 22 2001

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35383

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MARY AGNES CRESSER	OCTOBER 12, 2001	4:40 P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
001-34-2560	1☐ M 2☒ F	57 Yrs.			July 2, 1944	Rhode Island

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Mt. Airy	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1113 North Main Street	21771	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother'a Name (First, Middle, Maiden Sumeme)
unknown	Mary Marion Lavoie

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cindy Quill / daughter	20411 Afternoon Lane, Germantown, MD 20874

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hagerstown Crematory	10/15/01	Hagerstown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jacqueline Kiel	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Embolism	2 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Deep Venous Thrombosis	1 week
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Fracture Right lower extremity

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yea 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yea 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	June 2, 2001	1:00 A M	1☐ Yes 2☒ No	Fell at home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
home	1113 N. Main Mt Airy, MD 21771

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
▶	D35164	October 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Zarick, Jr. MD 1080 W. Patrick St. Frederick, MD 21703

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 15 2001	▶

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35384

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Carolina	Inda	Crum	October 15, 2001	12:45 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4402 Red Rose Court	Middletown	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-10-2979	1☐ M 2☒ F	83 Yrs.			July 9, 1918	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Knoxville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
327 East Mountain Road	21758	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates: X	1☐ Yes 2☒ No Specify: X	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Self Employed/Beautician	Hair Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles W. Eyler	Mary Frances Martell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia I. Tregoning, Daughter	327 East Mountain Rd., Knoxville, Md. 21758

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mount Olivet Cemetery,	Oct. 18, 2001	Frederick, Md.

21. Signature of Funeral Service Licensee: ▶ Richard E. Bof MO0255

22. Name and Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Stomach Cancer	8 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fatal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Niece's Home

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Joseph M. Haggerty MD	D32407	October 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Haggerty, M.D., 9707 Medical Center Drive, #300 Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	▶ D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35385

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thelma Elizabeth Critchfield

2. Date of Death (Month, Day, Year): October 23, 2001

3. Time of Death: 5:45 PM

4a. Facility Name *(If not institution, give street and number)*: 22388 Sandra Lane

4b. City, Town, or Location of Death: California

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 226-44-9476

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: January 19, 1916

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: California

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 22388 Sandra Lane

10f. Zip Code: 20619

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Shoe Sales Person

16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: William Holder

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Pearl Pyle

19a. Informent's Neme/Reletionship *(Type, Print)*: Robert Lee Holder, Sr. Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 22388 Sandra Lane California, Maryland 20619

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other placa)*: Metropolitan Crematory

Dete: 10/25/2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funerel Servica Licensee: Michael K Gardiner

22. Name end Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death)

a. cardiac arrest — Minutes

Due to (or es e consequence of):

b. coronary artery disease — years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es e consequence of):

c. arterio sclerotic disease — years

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier

29c. License number: D12597

29d. Date signed *(Month, Day, Year)*: 10-24-01

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Jeffrey Brown 23000 Moakley Street Leonardtown MD 20650

State Registrar

31. Dete filed *(Month, Dey, Year)*: OCT 29 2001

32. Registrer's Signeture

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Charles Edward Carroll, Sr.	October 25, 2001	5:27am M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-54-9566	1 [X] M 2 [ ] F	60 Yrs.			September 30, 1941	Washington DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Avenue	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
38573 Ted Drive	20609	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Cartographer	U.S. Government

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Joseph Benjamin Carroll, Sr.	Catherine Lovenia Harris

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
Rose Maria Carroll Wife	38573 Ted Drive Avenue, MD 20609

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1 [X] Buriel 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)	Charles memorial gardens	October 29,2001	Leonardtown, Maryland

21. Signature of Funerel Service Licensee	22. Name and Address of Facility
▶ [signature] M01206	Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death)	a. Myocardial Infarction	Sec
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of deeth 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	—	M	1 [ ] Yes 2 [ ] No	—

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)
—	—

29e. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D14285	10-26-01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Dr. William Boyd Leonardtown, Md. 20650

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signature
OCT 26 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Name: Charles Edward Carroll
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lois Raymond Camp
2. Date of Death: Month October Day 21 Year 2001
3. Time of Death: 10:00 PM
4a. Facility Name (If not institution, give street and number): 17036 Circle Lane
4b. City, Town, or Location of Death: Dameron
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 015-30-4459
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 11 1931
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Dameron
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17036 Circle Lane
10f. Zip Code: 20628
10g. Citizen of Whet Country?: U. S. A.

11. Maritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - Amerlcan Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): George W. Raymond
18. Mother's Neme (First, Middle, Maiden Sumame): Gladys Lucinda Harrington

19a. Informent's Name/Relationship (Type, Print): Frederick W. Camp Spouse
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 17036 Circle Lane Dameron MD 20628

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Metropolitan Crematory
Dete: 10/23/01
20c. Location - City or Town, Stete: Alexandria Virginia

21. Signature of Funeral Service Licensee: Michael K Gardiner
22. Nama and Address of Fecility: Mattingley-Gardiner Funeral HOme, P. A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet ceused tha death. Do not anter the moda of dying, such es cerdiec or raspiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediata Cause (Final diseese or condition resulting in deeth): e. metastatic epiglottic cancer — 4 mos.
Due to (or es e consequence ot):
Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that Initiated evants resulting in death) Lest
b.
Due to (or es e consequence ot):
c.
Due to (or es a consequence ot):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: John physician
29c. License number: D0055682
29d. Dete signed (Month, Day, Year): 10/22/01

30. Nema end address of person who completed causa of death (Item 23a) (Type, Print): Thomas M Wilkinson MD Shanti Medical Center Leonardtown MD

State Registrar

31. Data filed (Month, Day, Year): OCT 23 2001
32. Registrer's Signetura:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35388

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM GENE CHRISTMAN

2. Date of Death Month / Day / Year: OCTOBER 22, 2001

3. Time of Death: 5:00 AM

4a. Facility Name *(If not institution, give street and number)*: 1975 REESE ROAD

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 281-26-9282

6. Sex: XX 1 M 2 F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUGUST 8, 1927

9. Birthplace *(State or Foreign Country)*: OHIO

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CARROLL

10c. City, Town or Location: WESTMINSTER

10d. Inside City Limits: 1 Yes XX No

10e. Street and Number: 1975 REESE ROAD

10f. Zip Code: 21157

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 Never Married 2 XX Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? X Yes 2 No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XX No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: WHITE

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PAPER HANGER

16b. Kind of Business/Industry: WALL PAPER

17. Father's Name *(First, Middle, Last)*: WILLIAM GALE CHRISTMAN

18. Mother's Name *(First, Middle, Meiden Surneme)*: VIRGINIA EVELYN SMITH

19a. Informent's Name/Reletionship *(Type, Print)*: PAULETTE F. CHRISTMAN/WIFE

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1975 REESE RD, WESTMINSTER, MD 21157

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: GARRISON FOREST VETERANS

Date: 10/26/01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Susan Baker Myers

22. Name and Address of Facility: MYERS FUNERAL HOME 91 WILLIS STREET WESTMINSTER, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceuse the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic colon cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: None Known

23b. Did tobacco uas contributs to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was cese referred to medicel examiner? 1 Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 ☑ Residence 6 Other *(Specify)*

27. Manner of Death: 1 ☑ Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es stated. 2 **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Howard Saiontz

29c. License number: Md. # D15552

29d. Date signed *(Month, Day, Year)*: 10/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HOWARD SAIONTZ M.D. 555 SOUTH CENTER STREET, WESTMINSTER, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 23 2001

32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL 4

CPM
01-5916-013
ROBERT CARBAUGH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert L. Carbaugh	OCTOBER 18, 2001	11:07 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CARROLL COUNTY GENERAL	WESTMINSTER	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-66-3016	1[X] M 2[ ] F	44 Yrs.			Sept. 14, 1957	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Taneytown	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7 O'Brien Ave.	21787	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Woodworker	Maker of Stairways

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Raymond E. Carbaugh	Marie Warner

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Brenda L. Carbaugh - wife	7 O'Brien Ave. Taneytown, MD 21787

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Trinity Lutheran Cemetery	10-22-01	Taneytown, MD

21. Signature of Funeral Service Licensee: Richard Little Jr.

22. Name and Address of Facility: Little's F.H. 34 Maple Ave. Littlestown, PA 17340

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown

23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed? 1[X] Yes 2[ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1[X] Yes 2[ ] No

25. Was case referred to medical examiner? 1[X] Yes 2[ ] No

28. Place of Death (Check only one)
Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA
Other: 4[ ] Nursing Home 5[ ] Residence 8[ ] Other (Specify)

27. Manner of Death 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J M. T	O.C.M.E.	OCTOBER 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jack M. Titus M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 24 2001	Geneva B Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

WJ 12

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35390

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
LEON LAWSON DORSEY	OCTOBER 11, 2001	9:05 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-22-9887	1[X] M 2[ ] F	73 Yrs.			Dec. 8, 1927	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
32 A Sagner Drive	21701	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		janitor	school board

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Rod Dorsey	Olia Hosley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Ferguson / daughter	501 Prospect Blvd., Apt. 26A, Frederick, MD 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Fairview Cemetery	10/17/01	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Paul P. B Markey	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Renal Failure	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Congestive heart Failure	2 weeks
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Hypertension
- Diabetes type II

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown	1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0043091	10/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAEED ZAHID MD 801 TOLL HOUSE Ave, Frederick, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 15 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended item#19a&b perFH

Certificate of Death 10/15/01

Reg. No. 2001 35391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Edward	Bruce	Derrenbacher	October 12, 2001	9:10 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
191-12-2794	1 [X] M 2 [ ] F	78 Yrs.			April 3, 1923	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Florida	Highland	Sebring	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6750 U.S. 27 N. Unit G-3	33870	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	microbiologist	federal government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward Derrenbacher	Florence MacDodge

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley S. Derrenbacher / Wife ~~Edward B. Derrenbacher / son~~	6750 U.S. 27 N, Unit G-3 Sebring, FL 33870 ~~11021 Renner Rd., Woodsboro, MD 21798~~

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Hagerstown Crematory	10/14/01	Hagerstown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jacqueline Kreh	Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	3yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Dilated Cardiomyopathy	5yrs.
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Normal Pressure Hydrocephalus

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert L. Kaufmann	D-13971	10/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Kaufmann / 300 W. 9th Street, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 15 2001	▶ Brenda P Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

15+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35392

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KRISTI LYNN DART
2. Date of Death (Month, Day, Year): October 16, 2001
3. Time of Death: 7:35 A M
4a. Facility Name (If not institution, give street and number): 2910 East Boss Arnold Road
4b. City, Town, or Location of Death: Jefferson
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-68-5331
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 23, 1960
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Jefferson
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2910 East Boss Arnold Road
10f. Zip Code: 21755
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sr. Administrative Secretary
16b. Kind of Business/Industry: Insurance Company

17. Father's Name (First, Middle, Last): Norman H. Tooren
18. Mother's Name (First, Middle, Maiden Surname): Ruth A. Hull

19a. Informant's Name/Relationship (Type, Print): Clayton R. Dart, Jr. (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2910 East Boss Arnold Road, Jefferson, MD 21755

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: 10/17/01
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Brain Tumor — 6 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D0050880
29d. Date signed (Month, Day, Year): 10/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N. David Tzou, MD 56 Thomas Johnson Drive, Frederick, Maryland 21702

State Registrar

31. Date filed (Month, Day, Year): OCT 17 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
DONALD WRIGHT DUNCAN	OCTOBER 20, 2001	11:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-10-5856	1 [X] M 2 [ ] F	91 Yrs.			Feb. 24, 1910	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Mt. Airy	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6363 Albers Drive	21771	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	dispatcher	trucking company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank K. Duncan	Lucy Wright

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dona D. Wilson / daughter	6363 Albers Dr., Mt. Airy, MD 21771

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Pine Grove Cemetery	10/23/01	Mt. Airy, Maryland

21. Signature of Funeral Service Licensee ▶ Jacqueline Krul

22. Name and Address of Facility Stauffer Funeral Homes, P.A.
8 East Ridgeville Blvd, Mt. Airy, MD 21771

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Renal Failure	1 week
Due to (or as a consequence of):	b. Chronic Renal Failure	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Diabetic Nephropathy	5 years
Due to (or as a consequence of):	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Severe Mitral Regurgitation
Ischemic Cardiomyopathy

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Mary P. Howell M.D.	D46075	10/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Mary P. Howell / 170 TJ Drive, Frederick, MD 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 22 2001	▶ Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35394

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lureane Ard Douglas
2. Date of Death (Month, Day, Year): September 28, 2001
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): Bayside Care Center
4b. City, Town, or Location of Death: Lexington Park
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 251-32-6246
6. Sex: 1☐ M 2■ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 9, 1927
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1☐ Yes 2■ No
10e. Street and Number: 49425 Carroll Road
10f. Zip Code: 20653
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3■ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2■ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2■ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service
16b. Kind of Business/Industry: School System

17. Father's Name (First, Middle, Last): John Henry Ard
18. Mother's Name (First, Middle, Maiden Surname): Mary E. Pack

19a. Informant's Name/Relationship (Type, Print): Jane D. Carroll / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 49425 Carroll Road,Lexington Park, MD 20653

20a. Method of Disposition: 1■ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Summerville Cemetery
Date: 10/2/01
20c. Location - City or Town, State: Summerville, S.C.

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Recurrent Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Diabetes Mellitus

congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1■ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner**: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and mennar stated.

29b. Signature and title of certifier:
29c. License number: D19917
29d. Date signed (Month, Day, Year): 9/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James C. Boyd, M.D., 23415 Three Notch Road, California, Maryland 20619

State Registrar

31. Date filed (Month, Day, Year): OCT - 1 2001
32. Registrar's Signature: Geneva B. Spark

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35395

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Stephen Dunn

2. Date of Death Month / Day / Year: October 21, 2001

3. Time of Death: 23:05

4a. Facility Name *(If not institution, give street and number)*: 18273 Point Lookout Road

4b. City, Town, or Location of Death: Park Hall

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 160-28-9852

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 4, 1937

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Park Hall

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 18273 Point Lookout Road

10f. Zip Code: 20667

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1955-1959

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanical Engineer

16b. Kind of Business/Industry: Defense Contractor

17. Father's Name *(First, Middle, Last)*: Charles Francis Dunn

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Gallager

19a. Informant's Name/Relationship *(Type, Print)*: Janet Dunn Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18273 Point Lookout Road Park Hall MD 20667

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Face Cemetery

Date: 10/26/01

20c. Location - City or Town, State: Great Mills Maryland

21. Signature of Funeral Service Licensee: Michael K Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in death)

a. metastatic adenocarcinoma pancreas 4 mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior fo completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, end due fo the cause(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: DO 13[illegible]

29d. Date signed *(Month, Day, Year)*: 10.22.01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): John Renwick 24035 Three Notch Road Hollywood MD 20636

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 23 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#4&6perPHY,Item#26 perVerbalG801 11/06/01 EW **Certificate of Death** Reg. No. 2001 35396

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
Iola	Donaldson	October	5,	2001	3:45PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Alden Elder Care	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
192-22-4953	1☐ M 2☒ F	79 Yrs.					Sept. 20, 1922	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Columbia	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6695 Hawkeye Run	21044	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Cardboard Box Operator	Factory

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Barnes	Pearl Crockett

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ola Rawson -daughter	5 Street Williams Way Stafford, VA

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	White Chapel Cemetery	Oct. 13. 2001	Feasterville, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kevin A Moody	Rapp Funeral And Cremation Service 933 Gist Avenue Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular Infarction	5 Days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Abeda Ali Khan M.D.	D43323	October 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Abeda Ali, Khan 10794 Hickory Ridge Road, Columbia, MD 201044

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 15 2001	▶ Lenora B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35397

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Frank	Miller	Flanagan, Jr.	October 2, 2001	12:45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
25789 Whiskey Creek Road	Hollywood	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-48-5613	1☒ M 2☐ F	64 Yrs.			Feb. 27, 1937	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Hollywood	1☐ Yes 2☒ No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
25789 Whiskey Creek Road	20636	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade		Telephone Technician	Telephone Systems, Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Miller Flanagan, Sr.	Leila Ruth Warman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judith E. Flanagan (Spouse)	25789 Whiskey Creek Road, Hollywood, Maryland 20636

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Brinsfield-Echols	10/4/2001	Charlotte Hall, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward N. Brinsfield, Jr. M00052	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Pancreatic cancer	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A.D. Shah	D 47066	10.3.01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	
A.D. Shah, M.D.	Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 09 2001	▶ Penne B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35398

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Luke Ferguson, Jr.	September 28, 2001	9:53pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-54-6691	X 1 M 2 F	51 Yrs.			July 2, 1950	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Helen	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
39070 Chaptico Road	20635	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.)	14. Race - Americen Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 X Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Maintenance Man	Veteran's Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Luke Ferguson, Sr.	Agnes Mildred Lacey

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Agnes Vallandingham Mother	39070 Chaptico Road Helen MD 20635

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	St. John's Cemetery	10/2/01	Hollywood Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K Simms 100206	Mattingley-Gardiner Funeral Home P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. ARRYTHMIAS	24HRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as e consequence of): b. CARDIOMYOPATHY	5YLS
	Due fo (or as a consequence of): c. CORONARY ARTERY DISEASE.	5YLS.
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was cese referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ RGill MD	D56096	10/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Rajbinder Gill Hollywood ,Md. 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT - 1 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Robert Ferguson

GM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 26 per Physician
10/24/2001 Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35399

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Nelson W. Fincham, Sr.	October 23, 2001	05:30am

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
16 Railroad Avenue	Sykesville	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-12-4750	1☒M 2☐F	81 Yrs.			Dec. 16, 1919	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Sykesville	1☐Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7400 Village Road Apt. 11	21784	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Heavy Equipment Operator	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry W. Fincham	Clara Nicholson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Mary Hankins (Daughter)	16 Railroad Avenue Gaither, MD 21784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Harmony Grove Cemetery	10/26/01	West Friendship, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian K. Haight	HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. lung cancer (metastatic)	~1 year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	27. Manner of Death
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home ~~5☐Residence~~ 6☒Other (Specify) Residence	1☑Naturet 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D40850	October 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YVONNE OTTAVIANO MD 555 Center St. Westminster Md 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 24 2001	▶

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL 5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35400

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sister Rose Marie Gerace
2. Date of Death Month / Day / Year: Oct. 13, 2001
3. Time of Death: 10:30 A.M.
4a. Facility Name *(If not institution, give street and number)*: St. Vincent Care Center
4b. City, Town, or Location of Death: Emmitsburg ;
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 060-42-1369
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 23, 1911
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Emmitsburg,
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 335 South Seton Avenue
10f. Zip Code: 21727
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): College 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Social Work
16b. Kind of Business/Industry: Religious Community Daughters of Charity

17. Father's Name *(First, Middle, Last)*: Angelo Gerace
18. Mother's Name *(First, Middle, Maiden Surname)*: Frances Monaco

19a. Informant's Name/Relationship *(Type, Print)*: Sister Camilla Harant
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 333 S. Seton Ave., Emmitsburg, MD 21727

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: ST. JOSEPH'S P.H. — Date: 10/17/01
20c. Location - City or Town, State: EMMITSBURG, MD

21. Signature of Funeral Service Licensee: ▶ John M. Skiles
22. Name and Address of Facility: SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cancer of Pancreatitis with 6 mo

Due to (or as a consequence of):
b. metastases to liver and bowel

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Alan Carroll MD
29c. License number: D18705
29d. Date signed *(Month, Day, Year)*: OCT. 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 2001
32. Registrar's Signature: ▶ Bonnie G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35401

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wilbur Samuel Gordon

2. Date of Death (Month, Day, Year): October 20, 2001

3. Time of Death: 9:40am

4a. Facility Name *(If not institution, give street and number)*: Vindobona Nursing Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-36-6900

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 8, 1904

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Jefferson

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 5012 Holter Road

10f. Zip Code: 21755

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farming

16b. Kind of Business/Industry: Agriculture

17. Father's Name *(First, Middle, Last)*: Richard Nevin Gordon

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Mae Heffner

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Ruth Nill Gordon/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5012 Holter Road, Jefferson, maryland 21755

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Reformed Cemetery

Date: Oct 23, 2001

20c. Location - City or Town, State: Jefferson, Maryland

21. Signature of Funeral Service Licensee: Keith Lynn Robertson M00706

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. aspiration pneumonia — days

Due to (or as a consequence of): cerebrovascular disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: dementia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: MD D0057461

29d. Date signed *(Month, Day, Year)*: 10-22-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert Vandenbosche, M.D., 610 Ninth Avenue, Brunswick, Maryland 21716

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 22 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35402

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Howard William Gosnell, Jr.

2. Date of Death (Month, Day, Year): October 20, 2001

3. Time of Death: 3:27pm

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-14-8215

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 4, 1924

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Virginia

10b. County: Loudoun

10c. City, Town or Location: Lovettsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 38268 Long Lane

10f. Zip Code: 20180

10g. Citizen of What Country?: U. S. Of A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 43-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Car Inspector

16b. Kind of Business/Industry: B & O Railroad

17. Father's Name *(First, Middle, Last)*: Howard William Gosnell, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Virts

19a. Interment's Name/Relationship *(Type, Print)*: Mrs. Mildred I. Gosnell

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 38268 Long Lane, Lovettsville, VA 20180

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lovettsville Union

Date: Oct. 25, 2001

20c. Location - City or Town, State: Lovettsville, Virginia

21. Signature of Funeral Service Licensee: William J. Mallow

22. Name and Address of Facility: Loudoun Funeral Chapels, Leesburg, Virginia 20177-1316

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Septic shock — Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Methacillin Resistant Staph aureus, bilateral pneumonia dep.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure, Rectal carcinoma, S/P recent abdomino-perineal resection, essential thrombocytosis - Hypercoagulable state pulmonary asbestosis, Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chan-hing Ho

29c. License number: D47169

29d. Date signed *(Month, Day, Year)*: 10-24-2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ho, Chan-hing, M.D. 610 9th Ave., Brunswick, MD 21716

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 25 2001

32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CHARLES WILLIAM GILBERT
01-6014-021
B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35403

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES WILLIAM GILBERT, SR.

2. Date of Death (Month, Day, Year): OCT. 23, 2001

3. Time of Death: 1840 P M

4a. Facility Name (If not institution, give street and number): 8820 CHESTNUT GROVE ROAD

4b. City, Town, or Location of Death: Walkersville

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 214-28-0151

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 28, 1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Walkersville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10540 Daysville Road

10f. Zip Code: 21793

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Heavy Equipment Operator

18b. Kind of Business/Industry: Construction

17. Fether's Name (First, Middle, Last): Peter I. Gilbert

18. Mother's Name (First, Middle, Meiden Surneme): Ethel R. Stull

19a. Informent's Neme/Relationship (Type, Print): Mida Gilbert (Wife)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 10540 Daysville Road, Walkersville, MD 21793

20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other placa): Resthaven Mem. Gardens Date: 10/27/01

20c. Location - City or Town, Stete: Frederick, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

Immediete Ceuse (Finel disease or condition resulting in death): a. Cerebral Gunshot wound of Head

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last:

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximete Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnent in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel deeth 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Dete of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1 [ ] Yes 2 [X] No 3 [ ] Probebly 4 [ ] Unknown

24e. Was en autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [XX] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other (Specify) AT SCENE

27. Menner of Deeth: 1 [ ] Neturel 2 [ ] Accident 3 [XX] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 10/23/01

28b. Time of Injury: UK M

28c. Injury et Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject shot self

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify): IN Vehicle

28f. Location (Street end Number or Rurel Route Number, City or Town, State): 8820 Chestnut Grove RD,

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner es stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Lakon Locke MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): OCT. 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LAKON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 26 2001

32. Registrar's Signature: Brenda D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35404

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Agnes Eleanor Guy

2. Date of Death: Month October Dey 20, Year 2001

3. Time of Death: 9:50 PM

4a. Facility Name (If not institution, give street end number): St. Mary's Nursing Center

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 215-34-3339

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 91 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): February 22, 1910

9. Birthplece (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Hollywood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 45009 Irvin Street

10f. Zip Code: 20636

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Manager

16b. Kind of Business/Industry: Public Schools

17. Father's Name (First, Middle, Last): David Richard Dean

18. Mother's Neme (First, Middle, Meiden Surname): Myrtle Mae Copsey

19a. Informent's Neme/Reletionship (Type, Print): Mary Derby Daughter

19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 45009 Irvin Street Hollywood MD 20636

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): St. John's Cemetery

Dete: 10/24/01

20c. Location - City or Town, State: Hollywood Maryland

21. Signature of Funerel Service Licensee: Michael L. Gardiner

22. Neme end Address of Feciility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. Alzheimers Disease

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

failure to thrive

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the besis of exemineticn end/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: John L. Fenwick

29c. License number: D0130

29d. Date signed (Month, Dey, Year): 10-22-01

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): John Fenwick 24035 Three Notch Road Hollywood MD 20636

State Registrar

31. Dete filed (Month, Dey, Year): OCT 23 2001

32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35405

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aaron Adman Gilbert

2. Date of Death (Month, Day, Yesr): October 8, 2001

3. Time of Death: 7:34 PM

4a Facility Nsme (If not institution, give street and number): 40288 Waterview Drive

4b. City, Town, or Locatlon of Death: Mechanicsville

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 238 - 44 -7217

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. lest birthday): 69 Yrs.

If Under 1 Yesr: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): October 24, 1931

9. Birthplace (Stete or Foreign Country): North Carolina

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 40288 Waterview Drive

10f. Zip Code: 20659

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Mason

16b. Kind of Business/Industry: ResidentialConstruction

17. Fether's Name (First, Middle, Last): William Raymond Gilbert

18. Mother's Nsme (First, Middle, Maiden Surneme): Verga Gertrude Adams

19a. Informant's Name/Relationship (Type, Pnnt): Sarah Mason Gilbert Spouse

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 40288 Waterview Dr. Mechanicsville, MD 20659

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removsl from State 4 [ ] Donstion 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Charles Memorial Gardens

Date: 10/12/01

20c. Location - City or Town, State: Leonardtown Maryland

21. Signature of Funersl Service Licensee: [signature] M01206

22. Nsme and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicstions thet caused the desth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hesrt fsilure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediste Cause (Final disease or condition resulting in death)

a. Carcinomatosis — months

Due to (or as a consequence of):

Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lsst

b. Lung Cancer

Due to (or as a consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were sutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29s. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, snd due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion snd/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) edd manner sleted.

29b. Signsture end title of certifier: [signature] M.D

29c. License number: D06419

29d. Date signed (Month, Dey, Year): 10-9-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrick J. Jarboe 24035 Three Notch Road Hollywood MD 20636

State Registrar

31. Dete filed (Month, Day, Year): OCT 12 2001

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pnss.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35406

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA LUCILLE HOOD

2. Date of Death Month/Day/Year: OCTOBER 11 2001

3. Time of Death: 8:29 A M

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-22-7697

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): Oct. 16, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. Stata: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 817-A N. Market Street

10f. Zip Code: 21701

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Dacedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): self

16b. Kind of Businass/Industry: homemaker

17. Father's Name (First, Middla, Last): James O. Stroup

18. Mother's Name (First, Middle, Maiden Surname): Annie B. Routzahn

19a. Informant's Name/Ralationship (Type, Print): Jean Lucille Haines, daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 610 W. Patrick Street, Frederick, MD 21701

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cematary, cramatory or othar place): Mt. Olivet Cemetery

Date: 10/13/2001

20c. Location - City or Town, Stata: Frederick, Maryland

21. Signatura of Funaral Service Licensee: Ryan M. Berger M00999

22. Nama and Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on aach lina.

Immediate Cause (Final disease or condition resulting in death): a. CORONARY ARTERY DISEASE — Approximate Interval Between Onsat and Daath: Years

Dua to (or as a consequence of): b. ATHEROSCLEROSIS — Years

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaasa or injury that initiated events rasulting in daath) Last

Dua to (or as a consequance of): c.

Dua to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in tha past 12 months? 1☐ Yas 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Liva birth 2☐ Fatal daath 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of dalivary: Month Day Year

Part II. Dther significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS CONGESTIVE HEART FAILURE ATRIAL FIBRILLATION. CARCINOMA BREAST. VENOUS STASIS ULCS

23a. Did tobacco use contributa to tha causa of daath? 1☐ Yas 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to compiation of causa of daath? 1☐ Yas 2☐ No

25. Was casa referred to medical examiner? 1☐ Yas 2☑ No

26. Placa of Daath (Chack only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Daath: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Straat or Numbar or Rural Routa Numbar, City or Town, State)

29a. Cartifiar (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurrad at the tima, data and place, and due to tha cause(s) and manner as statad. 2☐ Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. Licensa number: D 18063

29d. Date signed (Month, Day, Year): 10/12/01

30. Name and address of person who completed causa of daath (Item 23a) (Typa, Print): ABDUL MAJEED 801 TOLLHOUSE AVE. FREDERICK MD 21701

State Registrar

31. Data filed (Month, Day, Year): OCT 15 2001

32. Registrar's Signature: B Sparks

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35407

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
PAULINE	HARTSOCK	October 20, 2001	6:50 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Homewood Retirement Center	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
268-09-4341	1☐M 2☒F	92 Yrs.			Nov. 7, 1908	Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryalnd	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
501 Fairview Ave.	21701	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1	Administrator Office	Office

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry Beckman	Elizabeth Hoelscher

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Kay August / daughter	501 Fiarview Ave./ Frederick, Maryland 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Gate of Heaven Cem.	10/26/2001	Cincinnati, Ohio

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Raymond Peterson	Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, Md 21702

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. STROKE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Atherosclerotic Vascular Disease

Due to (or as a consequence of):

c. + Chronic Atrial Fibrillation

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Joseph Ashwal MD	D26609	10/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Ashwal, 56 Thomas Johnson Dr./ Frederick, Maryland 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 22 2001	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35408

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Patricia	Ann	Haupt	October 20, 2001	4:43am M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-32-8470	1☐M 2☒F	64 Yrs.			May 8, 1937	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
160 Willowdale Drive, F-103	21702	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Administrative	Tag & Title Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Dewey Ford	Elsie Ellen McBride

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Franklin Haupt, Jr/Husband	160 Willowdale Dr, F-103, Frederick, MD 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removet from State 4☐Donetion 5☐Other (Specify)	Smithsburg Crematory	Oct 22,2001	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kathryn Roberson M00706	Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Obstructive Pulmonary disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Smoking	years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Diabetes

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probebly 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medicat examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	
1☑	**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐	**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D26516	October 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen J. Gilson, M.D., 1475 Taney Ave, Suite 204, Frederick, Maryland 21702-5127

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 22 2001	▶ Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 35409 Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Harold Wood Henderson	Oct. 22, 2001	3:02 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
178-14-4187	1 [X] M 2 [ ] F	83 Yrs.			July 15, 1918	PA.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Frederick	Myersville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9018 Myersville Rd.	21773	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	contract specialist	federal gov't.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harley H. Henderson	Nora Wood

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anna Henderson (Wife)	9018 Myersville Rd., Myersville, MD. 21773

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Resthaven Memorial Gardens	10/23	Frederick, MD.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, MD. 21769

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute intracerebral hemorrhage	15 min.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Cerebrovascular disease	years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Atrial fibrillation, anticoagulant therapy, coronary artery disease, carotid artery disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [✓] No	1 [ ] Yes 2 [ ] No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [✓] No	Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J Roessler MD	D20488	10/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES L. ROESSLER MD PO BOX 17 MIDDLETOWN, MD. 21769

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 25 2001	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35410

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary M. Higgins

2. Data of Death: Month October Day 24 Year 2001

3. Time of Death: 1058

4a. Facility Name (If not Institution, giva street and number): 19249 Bettys Avenue

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-32-9923

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 82 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): March 13, 1919

9. Birthplace (State or Foraign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Boonsboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 19249 Bettys Avenue

10f. Zip Code: 21713

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): (unknown) Lewis

18. Mother's Name (First, Middle, Maiden Surneme): Unknown

19a. Informant's Name/Relationship (Type, Print): Lynda Bailey - granddaughter

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 19249 Bettys Avenue, Boonsboro, Maryland 21713

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place): Laytonsville Cemetery

Date: 10/27/01

20c. Location - City or Town, State: Laytonsville, Maryland

21. Signature of Funeral Service Licensee: Olin L. Molesworth

22. Name and Addrass of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)

a. Congestive Heart Failure — 26yrs

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HTN

Due to (or as a consequence of):

c.

Due to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis

Atrial Fibrillation

23b. Did tobacco use contributa to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William F. Bodenheimer

29c. Licensa number: D0056826

29d. Date signed (Month, Day, Year): October 24 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): William F. Bodenheimer, MD 20311 Lappans Rd, Suite 103, Boonsboro, MD, 21713

State Registrar

31. Date filed (Month, Day, Year): OCT 26 2001

32. Registrar's Signature: G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Daniel	Forbes	Hammett	October 22, 2001	11:25pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-30-0795	1 ■ M 2 ☐ F	79 Yrs.			Mar. 11, 1922	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Leonardtown	1 ☐ Yes 2 ■ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
22555 Newtowne Neck Road	20650	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ■ Married 3 ☐ Widowed 4 ☐ Divorced	1 ■ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ■ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Truckdriver	State of Maryland

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Spencer Hammett	Elizabeth Woodburn

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary A. Hammett / Wife	22555 Newtowne Neck Road, Leonardtown, MD 20650

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ■ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Crematory Brinsfield-Echols	10-25-01	Charlotte Hall, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Edward N. Brinsfield, Jr. M00052	Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)	a. Congestive heart failure	years
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deaih) Last	Due to (or as a consequence of): b. Coronary artery disease	years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Data of delivery Month / Dey / Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

angina

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0055682	10/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Thomas Wilkinson Charlotte Hall, Md. 20622

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
OCT 25 2001	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Name: Daniel Forbes Hammett

1087

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 26 per Physician 10/24/2001 Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35412

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kenely Albert Hoyer
2. Data of Death Month: Oct Day: 18 Year: 2001
3. Time of Death: 11:30 am
4a. Facility Name *(If not institution, give street and number)*: Princess Royale Hotel 9100 Coastal Highway
4b. City, Town, or Location of Death: Ocean City
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 217-24-1051
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 72 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Nov 8 1928
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 929 Western Chapel Rd.
10f. Zip Coda: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Nevar Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☒Yas 2☐No If Yes, Giva Yaar or Dates: Korea
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐Yes 2☒No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Educetion *(Specify only highast grada completed)*: Elementery/Secondary (0-12): 12; Collega (1-4or 5+): 0
16a. Decedant's Usuel Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Mould maker
16b. Kind of Business/Industry: Glass products

17. Fether's Name *(First, Middle, Last)*: William Hoyer .
18. Mothar's Name *(First, Middla, Maidan Sumama)*: Mary Kuhl

19a. Informent's Name/Ralationship *(Type, Print)*: Audrey J. Blucher Daughter
19b. Meiling Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 927 Western Chapel Rd. Westminster, MD 21157

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stata 4☐Donetion 5☐Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or othar place)*: Lakeview Memorial Park
Data: 10- 22 2001
20c. Location - City or Town, Stata: Eldersburg, Maryland

21. Signeture of Funeral Service Licansee: John K Ryder
22. Nama and Addrass of Facility: Pritts Funeral Home and Chapel P.A. 412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Betwaen Onsat and Death

Immediate Cause (Finel disease or condition resulting in death): a. Dysrhythmia
Due to (or as a consequence of): COPD
Sequentially list conditions, if any, leading to immadieta ceusa. Entar Underlying Cause (Disease or Injury that initiated avants resulting in daath) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.: history of CHF, AODM & BPH

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No
24b. Wara autopsy findings available prior to completion of causa of daath? 1☐Yas 2☐No

25. Was casa referred to medical exeminar? 1☐Yes 2☒No
26. Placa of Daath *(Check only ona)*: Princess Royale
Hospital: 1☐Inpatiant 2☐ER/Outpatient 3☐DOA
Othar: 4☐Nursing Home 5☒Residence 6☒Othar *(Specify)*: Hotel

27. Mannar of Death: 1☒Neturel 2☐Accidant 3☐Suicide 4☐Homicida 5☐Pending Investigetion 6☐Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Dascribe how injury occurred
28e. Piece of Injury - At homa, ferm, straet, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stete)*

29a. Certifiar *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, date end place, and dua to the cause(s) and mennar es stated.
2☐**Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred at tha time, dete end piece, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: James L. Forsberg
29c. License number: D33561
29d. Date signad *(Month, Day, Year)*: 10/19/01
30. Name and address of person who completed causa of death (Item 23a) (Type, Print): James L. Forsberg, MD 1380 Progress Way, Suite 14, Eldersburg MD 21784

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 24 2001
32. Registrar's Signatura: Penna D Yonts

ORIGINAL

DHMH 16 Rev 6/95

WJL 20

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35413

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nellie Florence Howard
2. Date of Death Month Day Year: October 25 2001
3. Time of Death: 6:45 AM
4a Facility Neme *(If not institution, give street and number)*: Charles County Nursing & Rehab. Center
4b. City, Town, or Location of Deeth: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 213-14-5220
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 91 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day Year)*: July 26,1910
9. Birthplaca *(Stete or Foreign Country)*: DC Washington

Usual Residence of Decedent

10a. Stete: MD
10b. County: Charles
10c. City, Town or Location: Cobb Island
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 18700 Wicomico River Drive
10f. Zip Code: 20625
10g. Citizen of What Country?: USA

11. Merital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elamantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Book Keeper
16b. Kind of Business/Industry: Banking

17. Fether's Name *(First, Middle, Last)*: William J. Paris
18. Mother's Name *(First, Middla, Maidan Surnama)*: Florence Irene Chenoweth

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy T. Jones/Niece
19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)*: P.O. Box 335 Cobb Island,MD. 20625

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Brinsfield-Echols FH
Date: 10/26/01
20c. Location - City or Town, State: Charlotte Hall,MD

21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth)
a. CONGESTIVE HEART FAILURE
Due to (or as a consequenca of):
b. ISCHEMIC CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D53885
29d. Date signed *(Month, Dey, Year)*: 10/25/2001
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): VENKAT. S. KAMAVAN 6 POST OFFICE ROAD #101 WALDORF MD 20602

State Registrar

31. Date filed *(Month, Dey, Year)*: OCT 26 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AMND ITM #5 PR. F.H. G802 12-17-01 JAB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item#24a perVerbal

1- For State Registrar Amend item#25 perPHYG801 11/06/01 EW

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 35414

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Elbert	Woodrow	Hudson	October	28,	2001	12:08 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
242-56-8299 ~~268-36-2561~~	1 M X 2 F	62 Yrs.					01/31/39	North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Jefferson	Harpers Ferry	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
964 Chestnutwood Way	25425	US

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Heavy Equipment Operator	Pleasant Excavating

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Paul Hudson	Dorothy Matthis Hudson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty Hudson (Wife)	964 Chestnutwood Way, Harpers Ferry, WV 25425

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donetion 5 Other (Specify)	Smithsburg Crem.	11/2/01	Smithsburg, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Charles M. Brown	Jefferson Chapel Funeral Home P.O. Box 838, Charles Town, WV 25414

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDIAL ISCHEMIA	hours
Due to (or as a consequence of):	b. Pneumonia	hours.
Due to (or as a consequence of):	c. metastatic Gastric Cancer	months.
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cancer Cachexia

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ X A.Z. HEGAZI, MD	D44164	10-28-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A.Z. HEGAZI, MD, 801 TOLLHOUSE Ave, Bld F, Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	Jennifer B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35415

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BERNEASE MARIE KLINE
2. Date of Death Month: 10 Day: 15 Year: 2001
3. Time of Death: 9:27 P M
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213-18-8369
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7-12-1919
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Poolesville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 19025 Hemptown Court
10f. Zip Code: 20837
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Bernard Sier
18. Mother's Neme *(First, Middle, Meiden Surname)*: Cora Unberger

19a. Informant's Name/Relationship *(Type, Print)*: Dottie Beverly/daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 19025 Hemptown Court, Poolesville, MD 20837

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Mt. Olivet Cemetery Date: 10-19-2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death)
a. Cardiac arrest — Approximate Interval Between Onset and Death: minutes

Due to (or as a consequence of):
b. Sepsis — hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of deeth 5☐Other *(specify)* 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause ol deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: S. Abulfaraj, MD
29c. License number: D31391
29d. Date signed *(Month, Dey, Year)*: October 16 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Suhair Abulfarag, 9901 Medical Center Dr., Rockville, MD 20850

State Registrar

31. Date filed *(Month, Dey, Year)*: OCT 18 2001
32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35416

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SISTER ROSE MARIE KELLY

2. Date of Death Month Day Year: OCTOBER 22,2001

3. Time of Death: 3:37 AM

4a Facility Name *(If not institution, give street and number)*: ST. VINCENT CARE CENTER

4b. City, Town, or Location of Death: EMMITSBURG

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 207-40-1551

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG.4,1917

9. Birthplace *(State or Foreign Country)*: WASH, DC

Usual Residence of Decedent

10a. State: MD

10b. County: FREDERICK

10c. City, Town or Location: EMMITSBURG

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 335 S. SETON AVE.

10f. Zip Code: 21727

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER

16b. Kind of Business/Industry: SISTER OF NOTRE DAME

17. Father's Name *(First, Middle, Last)*: EUGENE JOSEPH KELLY

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY MILLS

19a. Informant's Name/Relationship *(Type, Print)*: SUPERIOR SISTER MARY ADELE WHITE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19 WINDWARD CT. THURMONT, MD. 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SISTERS OF NOTRE DAME

Date: 10/24

20c. Location - City or Town, State: ILCHESTER, MD.

21. Signature of Funeral Service Licensee: John M. Skiles

22. Name and Address of Facility: SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End stage Alzheimer Disease — 8 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bonita J. Krempel-Porter DO

29c. License number: 20/H44037

29d. Date signed *(Month, Day, Year)*: OCTOBER 22,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BONITA J. KREMPEL-PORTER DO 57 WATER STREET THURMONT, MD 21788

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 23 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. 2001 35417

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ernest Francis Ketner	October 13, 2001	10:05 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-03-5074	1 X M 2 ☐ F	79 Yrs.					September 13 1922	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	California	1 ☐ Yes 2 X No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
44054 Fieldstone Way	20619	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Owner/Operator	Business Machines

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Patrick Francis Ketner	Alberta Katherine Thomas

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy T. Ketner Wife	44054 Fieldstone Way California MD 20619

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Mt. Comfort Cemetery	10/17/01	Alexandria Virginia

21. Signature of Funeral Service Licensee: Michael Lewis Gardiner Jr

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P. A. PO Box 270 Leonardtown MD 20650

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	Hypertension	4-5 years
Due to (or as a consequence of): c.	Diabetes	4 years
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnent in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent et time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown	1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D33470	10/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Bhasker Jhaveri Shah Associates p.o. box 640 Hollywood, md 20636

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Name: ernest frances

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 22 2001	Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended item#14perFH FCHD,KS **Certificate of Death** Reg. No. 2001 35418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HECTOR MANUEL LEBRON
2. Date of Death Month Day Year: OCTOBER 17, 2001
3. Time of Death: 2:20 A M
4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSP.
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 050-40-1416
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 4, 1948
9. Birthplace (State or Foreign Country): PUERTO RICO

Usual Residence of Decedent

10a. State: MD.
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 11 TANEY AVE.
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify: PUERTO RICAN
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAINTANCE
16b. Kind of Business/Industry: NYC HOUSING AUTHORITY
17. Father's Name (First, Middle, Last): Thomas LEBRON
18. Mother's Name (First, Middle, Maiden Surname): JOSEFINE CRUZ
19a. Informant's Name/Relationship (Type, Print): JOSEFINE CRUZ (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 500 N. BENTZ ST APT 37 FRED, MD 21701
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FAIRVIEW CEM. Date: OCT. 23, 2001
20c. Location - City or Town, State: FRED. MD.
21. Signature of Funeral Service Licensee: Gary L. Rollins
22. Name and Address of Facility: GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST FRED. MD. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ADENOCARCINOMA of THE LUNG — 27 MO.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: George I. Smith M.D. VPMA
29c. License number: D 10587
29d. Date signed (Month, Day, Year): 10/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE I. SMITH, M.D. VICE-PRES MED AFFAIRS FREDERICK HIGH HOSP FREDERICK, MD 21701

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001
32. Registrar's Signature: Geneva B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification; To Be Completed by Physician/Medical Examiner

3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35419

Physician /Medical Examiner

1. Decedent's Nema *(First, Middla, Last)*: Rosemary Elliott LaMarr
2. Dete of Death Month Dey Yeer: October 17, 2001
3. Time of Death: 3:00 AM
4e Facility Neme *(If not institution, give street end number)*: 45010 Millstone Lane
4b. City, Town, or Location of Death: Hollywood
4c. County of Deeth: St. Mary's

Funeral Director

5. Social Security Number: 313-16-6342
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs.
If Under 1 Yeer: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Yeer)*: March 28, 1921
9. Birthplaca *(State or Foreign Country)*: Indiana

Usuet Residence of Decedent

10a. Stata: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Hollywood
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 45010 Millstone Lane
10f. Zip Code: 20636
10g. Citizen of Whet Country?: U S A

11. Marital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondery (0-12): 12th; Collega (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fathar's Name *(First, Middle, Last)*: Earl Elliott
18. Mother's Name *(First, Middle, Maiden Surneme)*: Clarice Monroe

19a. Informant's Neme/Reletionship *(Type, Print)*: Charles LaMarr (Spouse)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 45010 Millstone Lane, Hollywood, Maryland 20636

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Brinsfield-Echols
Dete: 10/18/01
20c. Location - City or Town, State: Charlotte Hall, Marylan

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Nama end Address of Facility: Brinsfield Funeral Home, P.A. P.O. box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one causa on eech line.

Approximete Interval Between Onset end Deeth

Immedlete Cause (Final diseese or condition resulting in deeth)
a. Sepsis
Due to (or es e consequence of):
b. Chronic Renal failure

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest
Due to (or as e consequence of):
c. Chronic Obstructive
Due to (or es e consequence of):
d. Pulmonary Disease

Pert II. **Other significant conditions** contributing to death but not resulting in the undertying ceuse given in Pert I.: Ulcerative colitis

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings aveileble prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes cese referred to medical examinar? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Naturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, data and place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On tha basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner stated.
29b. Signatura and titla of certifier
29c. Licansa number: D23634
29d. Data signed *(Month, Day, Year)*: 10/18/01.
30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): V.K. Shah Hollywood, Maryland 20636

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 19 2001
32. Registrer's Signeture

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35420

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leonard David Lacey
2. Date of Death (Month, Day, Year): September 30, 2001
3. Time of Death: 10:00 PM
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 218-32-3714
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 65 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: December 26, 1935
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Chaptico
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10a. Street and Number: 23590 Hurry Road
10f. Zip Code: 20621
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Stock Clerk
16b. Kind of Business/Industry: Grocery Store

17. Father's Name *(First, Middle, Last)*: Walter Benjamin Lacey
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Ada Quade

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Lacey Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23590 Hurry Road Chaptico MD 20621

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sacred Heart Cemetery
Data: 10/4/01
20c. Location - City or Town, State: Bushwood Maryland

21. Signature of Funeral Service Licensee: K Simms MD1206
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P. A. PO Box 270 Leonardtown MD 20650

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA OF THE PANCREAS — 5 MONTHS

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last
b.

Due to (or as e consequance of):
c.

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Panding investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To tha best of my knowledge, death occurred at tha time, data and place, and due to tha cause(s) and mannar as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Robert J Bauer MD
29c. License number: D00 14168
29d. Date signed *(Month, Day, Year)*: 10/1/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT J. BAUER, MD 28170 OLD Village Rd. MECHANICSville, md 20659

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT - 1 2001
32. Registrer's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35421

GEORGE LEONARD JR.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): GEORGE JOSEPH LEONARD, JR.

2. Date of Death (Month, Day, Year): OCTOBER 24, 2001

3. Time of Death: 1:35 AM

4a. Facility Name (If not institution, give street and number): CIVISITA MEDICAL CENTER

4b. City, Town, or Location of Death: LAPLATA

4c. County of Death: CHARLES

5. Social Security Number: 164-36-6076

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 31, 1948

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Charles

10c. City, Town or Location: Marbury

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4335 Creeds Mill Place

10f. Zip Code: 20658

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Brick Mason

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): George Joseph Leonard,Sr.

18. Mother's Name (First, Middle, Maiden Surname): Betty Davis Leonard

19a. Informant's Name/Relationship (Type, Print): Cora Lee Leonard/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4335 Creeds Mill Place,Marbury,Md.20658

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Ignatius Cem.

Date: 10/27/01

20c. Location - City or Town, State: Hill Top, Maryland

21. Signature of Funeral Service Licensee: David C. Echols M00945

22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567, LA PLATA,MD. 20646

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR FIBRILLATION — ONG HR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE — YRS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joel Sewchand

29c. License number: D-29646

29d. Date signed (Month, Day, Year): 10,24,01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOEL SEWCHAND M.D. 118 LA GRANGE AVE. PO. BOX 988 LAPLATA MD. 20646

State Registrar

31. Date filed (Month, Day, Year): OCT 26 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 35422
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ROBERT WALKER MYERS, JR.	OCTOBER 13, 2001	8:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHAMPTON MANOR NURSING HOME	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-28-1147	1☒M 2☐F	74 Yrs.			AUG 21, 1927	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	FREDERICK	FREDERICK	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5654 STONE ROAD	21702	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	-	SUPERVISOR	MONTGOMERY COUNTY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ROBERT MYERS	JULIA STUP

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HELEN BLANK MYERS / WIFE	5654 STONE ROAD, FREDERICK, MD 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT. ZION LUTHERAN CH.	10/17/2001	FREDERICK, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Peter B. MacKay	STAUFFER FUNERAL HOMES, P.A. 1621 OPOSSUMTOWN PIKE, FREDERICK, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gangrene Foot	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Peripheral Vascular Disease	years
	c. Due to (or as a consequence of): Diabetes Mellitus Type II	years
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the ceuse of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.
2☐**Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Casper E. Cline III MD	D 16628	10/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Casper E. Cline III, M.D. 300 W. 9th St. Frederick MD 2170

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	▶ Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35423

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christa H. Miller
2. Data of Daath: Month October Day 15 Yaar 2001
3. Time of Death: 3:15 PM
4a. Facility Name (If not institution, giva street and number): Homewood at Crumland Farms
4b. City, Town, or Location of Daath: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 546-18-2258
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 98 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Aug. 5, 1903
9. Birthplace (Stata or Foreign Country): Arizona

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 204 Park Avenue
10f. Zip Code: 21771
10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fathar's Nama (First, Middle, Last): James Clinton Nowlin
18. Mother's Name (First, Middle, Maiden Surname): Anna Buchanan

19a. Informant's Name/Relationship (Type, Print): Barbara Darneal / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 187 Mt. Airy, Maryland 21771

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Nama of cemetary, cramatory or other place): Hagerstown Crematory
Data: Oct, 17, 2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, Maryland 21771

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death): a. Atherosclerotic Heart Disease — years

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to compiation of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifiar: [signature] MD
29c. Licansa number: D16428
29d. Date signed (Month, Day, Year): 10/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline 300 W. 9th St Frederick, MD 21701

State Registrar

31. Data filed (Month, Day, Year): OCT 18 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other trauma tic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Known to Physician as Christa H. Miller D.O.D 10/15/01 T.O.D 3:15 pm

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MATILDA GRACE MYERS	October 16, 2001	11:02 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Record Street Home	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-48-2749	1☐M 2☒F	91 Yrs.			May 6, 1910	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
115 Record Street	21701	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Owner & Operator	Myland Farm

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Zacharius U. Firor	Bessie Violet Isanogle

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bessie B. Bryant (Daughter)	8108 Canterbury Drive, Frederick, Maryland 21704

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removat from State 4☐Donetion 5☐Other (Specify)	Blue Ridge Cemetery	10/19/01	Thurmont, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	4 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident
Diabetes mellitus
Atrial fibrillation

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Domiciliary Home

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Francis E Becker MD	030496	10/18/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francis E. Becker MD 300 W 7th St Frederick Md 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	Penny B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35425

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JAMES	RENE	MICHAUD	October 17, 2001	3:00 A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3501 Runkles Drive	Monrovia	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
183-46-9580	1☒M 2☐F	46 Yrs.			Feb. 20, 1955	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Monrovia	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3501 Runkles Drive	21770	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Self employed	Design group

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
J. Ellery Michaud	Esther Griffith

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dr. J. Ellery Michaud/father	877 Pininsula Indian Lake / Central City, PA 15926

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hagerstown Crematory	10-18-2001	Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike/ Frederick, Maryland 21702

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Colon cancer — 12 months.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Wes decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ross C. Donehower, DIRECTOR, MEDICAL ONCOLOGY	D23675	October 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROSS C. DONEHOWER, MD JOHNS HOPKINS ONCOLOGY CTR, 401 N. Broadway, Baltimore, MD 21205

10

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 18 2001	Jeanne G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Donna L. Moberly
CJ
01-5978-021

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 110701:ITEMS#2a,27 per ME GAIL SS

Reg. No. 2001 35426

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donna Lee Moberly

2. Date of Death Month: October Day: 22 Year: 2001

3. Time of Death: 12:26 P.M

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-88-4907

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 3, 1960

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 7 West 5th Street

10f. Zip Code: 21701

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Food Service

18b. Kind of Business/Industry: Convenience Store

17. Fether's Name (First, Middle, Last): Otis Whitmore

18. Mother's Name (First, Middle, Maiden Sumame): Goldie Whitmore

19a. Informant's Name/Relationship (Type, Print): Dennis Earl Moberly, Sr

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 West 5th Street, Frederick, Maryland 21701

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) Entombment

20b. Placa of Disposition (Name of cemetery, crematory or other place): Resthaven Memorial Gardens

Date: Oct. 26, 2001

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Berger MO0999

22. Name and Address of Facility: Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetioes thet caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the ceuse of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Was an eutopsy performed? 1☒Yes 2☐No

24b. Were eutopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kirgus

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): October 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 24 2001

32. Registrar's Signature: D Aparicio

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35427

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Henry Myers Sr
2. Date of Death Month Day Year: October 22, 2001
3. Time of Death: 1:20 pm
4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-2165
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 15, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 320 Braddock Avenue
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter
18b. Kind of Business/Industry: Hospital Maintenance

17. Father's Name (First, Middle, Last): John Wesley Myers
18. Mother's Name (First, Middle, Maiden Surname): Stella Virginia Blank

19a. Informant's Name/Relationship (Type, Print): Barbara A. Stone/Sister-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6606 Tuscarora Drive, Frederick, maryland 21702

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthave Mem Gardens
Date: Oct 25, 2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Kenneth Lynn Roberson M00706
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21701

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease

Approximate Interval Between Onset and Death: Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M Tolino MD
29c. License number: D51610
29d. Date signed (Month, Day, Year): October 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Tolino, M.D., 1475 Taney Ave, Sutie 201, Frederick, Maryland 21702-5127

4

State Registrar

31. Date filed (Month, Day, Year): OCT 24 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 35428

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Year	3. Time of Death
Monroe Russell Moss	October 22, 2001	9:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Citizens Nursing Home	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-67-5271	1☒M 2☐F	83 Yrs.			Oct. 18, 1918	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8903A Yellow Springs Road	21702	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1944-1945	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Pressman	Printing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William H. Moss	Lillie Harris

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary N. Moss, wife	8903A Yellow Springs Road, Frederick, MD 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Olivet Cemetery	10/26/2001	Frederick, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ryan M. Berger M00999	Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cancer of Pancreas	4 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23a. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Casper E. Cline III MD	D16428	October 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline, III, MD, 300 West 9th Street, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 24 2001	▶ Penny B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35429

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaar	3. Tima of Daath
Willard Austin Mettam, Jr.	October 27, 2001	1:45 P M

4a. Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Numbar	6. Sex 1☐M 2☐F	7. Aga (In yrs. last birthday)	If Undar 1 Year: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (Stata or Foraign Country)
216-74-0498	1☒M 2☐F	41 Yrs.			March 2 1960	Maryland

Usual Rasidance of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	St. Mary's	Ridge	1☐Yas 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
49461 Bayne Road	20680	U.S.A.

11. Marital Status	12. Was Decadant Evar in U.S. Armed Forcas? If Yas, Giva Yaar or Datas:	13. Was Dacadant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.)	14. Raca - Amaricen Indian, Black, White, atc.
1☒Navar Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yas 2☒No	1☐Yas 2☒No Specify:	Specify: White

15. Decadent's Education (Specify only highest grada completed)		16a. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
11		Carpenter	Residential Construction

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middla, Maidan Sumama)
Willard Austin Mettam, Sr.	Rita VanLill Raley

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda)
John Bartley Mettam Brother	48600 Deep Cove Lane PO Box 421 Ridge MD 20680

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of cematary, crematory or othar placa)	Data	20c. Location - City or Town, Stata
1☐Burial 2☒Cremation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)	Metropolitan Crematory	10/30/01	Alexandria Virginia

21. Signatura of Funeral Service Licensee	22. Name and Address of Facility
Michael K Gardiner	Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona ceusa on aach lina.

		Approximata Intarval Batwaan Onsat and Daath
Immediata Causa (Finat disaasa or condition rasulting in death)	a. Aspiration Pneumonia	11 Days
Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last	b. Dua to (or as a consequance of):	
	c. Dua to (or as a consequance of):	
	d. Dua to (or as a consequance of):	

IF FEMALE: 23b. Was decedent pregnant in tha past 12 months? 1☐Yas 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Liva birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Othar (specify) 9☐Unknown	23d. Data of dalivary Month Day Year

Part II. Other significant conditions contributing to daath but not rasulting in the undarlying causa givan in Part I.

Cerebral Vasculitis

23a. Did tobacco usa contributa to tha causa of daath? 1☐Yas 2☐No 3☒Probably 4☐Unknown		
	24a. Was an autopsy performed? 1☐Yas 2☒No	24b. Wara autopsy findings availabla prior to compiation of causa of daath? 1☐Yas 2☐No

25. Was casa rafarrad to madical examinar? 1☐Yas 2☒No	26. Placa of Daath (Check only ona) Hospital: 1☒Inpatiant 2☐ER/Outpatiant 3☐DOA Othar: 4☐Nursing Homa 5☐Rasidence 6☐Othar (Specify)

27. Mannar of Daath	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurrad
1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not ba datarmined		M	1☐Yas 2☐No	
	28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)			28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one) 1☒ **Certifying Physician:** To tha bast of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and dua to tha ceusa(s) and mannar stated.

29b. Signatura and title of cartifiar	29c. Licensa number	29d. Data signad (Month, Day, Yaar)
[signature]	D45666	10-29-01

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Typa, Print)

14300, CALVERT FOX CIR 124, BOWIE MD 20715

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
OCT 29 2001	[signature]

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35430

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie Pfahl McIntyre

2. Date of Death (Month, Day, Year): October 21, 2001

3. Time of Death: 14:40

4a. Facility Name (If not institution, give street and number): Bayside Nursing Center

4b. City, Town, or Location of Death: Lexington Park

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 271-01-3974

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 10, 1916

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11 Marshall Road

10f. Zip Code: 20602

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Law Office

17. Father's Name (First, Middle, Last): Frank Pfahl

18. Mother's Name (First, Middle, Maiden Surname): Mary Heffner

19a. Informant's Name/Relationship (Type, Print): Lewis McIntyre Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14095 Burntstone Road Hughesville MD 20637

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Hills Cemetery

Date: 10/24/01

20c. Location - City or Town, State: Asheville NC

21. Signature of Funeral Service Licensee: ▶ Michael K Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Failure

Due to (or as a consequence of):

b. Coronary Artery Disease yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Patrick Jarboe MD

29c. License number: D 06419

29d. Date signed (Month, Day, Year): 10-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrick Jarboe 24035 Three Notch Road Hollywood MD 20636

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

(B)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35431

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ruth Phillips Meekins	October 22, 2001	0849 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Memorial Hospital	Easton	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-32-8892	1☐M 2☒F	102 Yrs.			July 31 1899	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Dorchester	Cambridge	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1200 School Street	21613	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	2	volunteer services director	state hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Luther Phillips	Margaret Ann Mills

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret Ann Bramble - daughter	P. O. Box 157, Trappe, MD 21673

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cambridge Cemetery	10/25	Cambridge, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John W. Thomas	Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

To Be Completed by Funeral Director

Ruth P. Meekins

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 6058.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. sepsis	24 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Nancy J. Snow	H53369	10/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy Snow, M.D. 219 S. Washington St., Easton, MD 21601

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature
	OCT 24 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item#23aptII perPHYG801 11/06/01 EW

Certificate of Death

Reg. No. 2001 35432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lola Maude Malm
2. Date of Death: Month October Day 8 Year 2001
3. Time of Death: 3:37p. M
4a. Facility Name (If not institution, give street and number): 7224 Rock Hall Road
4b. City, Town, or Location of Death: Rock Hall
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 158-18-4582
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 100 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 1, 1901
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Rock Hall
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 7224 Rock Hall Road
10f. Zip Code: 21661
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Edward Turner
18. Mother's Name (First, Middle, Maiden Surname): Amanda Jones

19a. Informant's Name/Relationship (Type, Print): Joyce Mary Krumpet/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7224 Rock Hall Road, Rock Hall, Maryland 21661

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chester Cemetery
Date: 10/11/2001
20c. Location - City or Town, State: Chestertown, Maryland

21. Signature of Funeral Service Licensee: Kirk A. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia — 3 days
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Cardiovascular Disease
Dementia
~~Slip Fractured Right hip~~

23e. Did tobacco use contribute to the cause of death? 1☐Yes ~~2☒No~~ 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes ~~2☒No~~
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes ~~2☒No~~

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home ~~5☒Residence~~ 8☐Other (Specify)

27. Manner of Death: ~~1☒Natural~~ 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and ~~title of certifier~~: Susan K. Ross M.D.
29c. License number: D17036
29d. Date signed (Month, Day, Year): 10/9/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan K. Ross M.D. 516 Washington Ave Chestertown Md 21620

State Registrar

31. Date filed (Month, Day, Year): OCT 11 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

23a ptII

K2-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
NETTIE VIRGINIA MEISE	10	13	2001	8:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
120 QUEEN COLONY HEIGHTS	STEVENSVILLE	QUEEN ANNE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-18-4218	1☐ M 2☒ F	83 Yrs.					06/02/1918	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	QUEEN ANNE'S	STEVENSVILLE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
120 QUEEN COLONY HEIGHTS	21666	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
W. EDWARD THAWLEY	MARGARET COURSEY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GRATHEL BANKS / NIECE	120 QUEEN COLONY HEIGHTS STEVENSVILLE, MD 21666

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	CHESAPEAKE CREMATION CTR.	10/18/01	STEEVENSVILLE, MD

21. Signature of Funeral Service Licensee: Chad M. Hofstetter

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD CHESTER, MARYLAND 21619

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. BRAIN TUMOR	3 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism
Hypertension
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Jamie Harms MD	D41339	10-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMIE HARMS MD 130 LOVE POINT RD. STEVENSVILLE, MD 21666

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 19 2001	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.A. 33A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 110601:ITEMS#23a,ptII,23b,25,27 per ME G801 ss

Certificate of Death

Reg. No. 2001 35434

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DEBRA FAWN MORRIS

2. Date of Death (Month, Day, Year): JUNE 29 2001

3. Time of Death: 10:00 PM

4a. Facility Name (If not institution, give street and number): 100 FOREST ROAD

4b. City, Town, or Location of Death: GRASONVILLE

4c. County of Death: QUEEN ANNE

Funeral Director

5. Social Security Number: 235-88-6673

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 3, 1953

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD

10b. County: QUEEN ANNE

10c. City, Town or Location: GRASONVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 100 FOREST ROAD

10f. Zip Code: 21638

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): -0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SCHOOL BUS DRIVER

16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name (First, Middle, Last): DEXTER DAWSON

18. Mother's Name (First, Middle, Maiden Surname): MYRNA LAFFERTY

19a. Informant's Name/Relationship (Type, Print): GEORGE WALLACE MORRIS/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 FOREST ROAD, GRASONVILLE, MD 21638

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): STEVENSVILLE CEMETERY

Date: 7-3-2001

20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: Paul M. Helfenbein

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619

Physician /Medical Examiner

23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Anaphylactic Shock — immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, OBESITY, ASTHMA, HYPOCHOLESTEREMIA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jonathan Forman, MD

29c. License number: D0023811

29d. Date signed (Month, Day, Year): 7/2/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JONATHAN FORMAN, M.D., 1406 B S. CRAIN #304, GLEN BURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amend Item 29c per verbal from B.O.P. 10/23/2001 Carroll County, wjl

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 35435

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HAZEL O. NEAL
2. Date of Death Month: OCT Day: 16 Year: 2001
3. Time of Death: 1849
4a. Facility Name *(If not institution, give street and number)*: HOWARD COUNTY GENERAL HOSPITAL, COLUMBIA
4b. City, Town, or Location of Death
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 214-34-3391
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. If Under 1 Year Months Days; If Under 24 Hrs. Hours Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 24 1917
9. Birthplace *(State or Foreign Country)*: Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7147 Smooth Path
10f. Zip Code: 21045
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)* Elementery/Secondary (0-12): 9 College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Custodian
16b. Kind of Business/Industry: Howard County Public Schools
17. Father's Name *(First, Middle, Last)*: Adolphus Callahan
18. Mother's Name *(First, Middle, Maiden Surname)*: Sally Brown
19a. Informant's Name/Relationship *(Type, Print)*: Janet Carey (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8722 Cardinal Forest Circle, Laurel, MD 20723
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lake View Mem. Park
Data
20c. Location - City or Town, State: 10/22/01 Sykesville MD
21. Signature of Funeral Service Licensee: Brian L. Haight
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville MD 21784

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA — MINUTES

Due to (or as a consequence of):
b. STROKE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)* Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mark King
29c. License number: D38026 ~~BK1112161~~
29d. Date signed *(Month, Day, Year)*: 10-22-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark King, MD Howard Co. General Hospital, 5755 Cedar Ln. Columbia MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 23 2001
32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35436

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BERNARD A. PETERSON

2. Date of Death Month Day Year: OCTOBER 12 2001

3. Time of Death: 14:30pm

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 338-14-7115

6. Sex: 1☑ M 2☐ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 15 1922

9. Birthplace *(State or Foreign Country)*: IL

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: POOLESVILLE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 17104 CHISWELL ROAD

10f. Zip Code: 20837

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☑ Yes 2☐ No. If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRADE ANALYST

16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name *(First, Middle, Last)*: ALBERT PETERSON

18. Mother's Name *(First, Middle, Maiden Surname)*: ANNIE LAPPIN

19a. Informant's Name/Relationship *(Type, Print)*: ROBERT PETERSON/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 523A EPPING FOREST RD., ANNAPOLIS, MD 21401

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GATE OF HEAVEN CEM.

Date: 10/16

20c. Location - City or Town, State: SILVER SPRING, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: HILTON FUNERAL HOME, P.O. BOX 86, BARNESVILLE, MD 20838

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA — DAYS

Due to (or as a consequence of):

PARKINSONS DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joseph A Ball MD

29c. License number: D 53317

29d. Date signed *(Month, Day, Year)*: October 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH A. BALL, MD 16220 FREDERICK RD., #213, GAITHERSBURG, MD 20877

10

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 15 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Ammended#26 per MD.FCHD SL **Certificate of Death** 10-26-01 Reg. No. 2001 35437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Dey / Yeer	3. Time of Death
Emmett R. Pearre Sr	October 22 2001	3:10a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
15501 Comus Road	Clarksburg	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthplece (State or Foreign Country)
579-07-5639	1☒M 2☐F	90 Yrs.			Dec. 20 1910	Maryland

Usuel Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Clarksburg	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
15501 Comus Road	20871	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
7		Painter	Home Improvement

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
William H. Pearre	Alice S. Hickman

19e. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Donna B. Gordon/ Daughter	24502 Newbury Road, Gaithersburg, Maryland 20882

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, State
1☒Buriel 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)	Mt.Olivet Cemetery	Oct.25.2001	Frederick, Maryland

21. Signature of Funeral Service Licensee ▶ Todd D. Wynne

22. Name and Address of Facility: Olin L. Molesworth P. A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in deeth)	a. ALZheimeRS Disease	1year
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last	Due to (or as e consequence of): b.	
	Due to (or es a consequence of): c.	
	Due to (or es a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnency	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnency 4☐Pregnant et time of deeth 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24e. Was en autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Deeth (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) hospice

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es steted. 2☐ **Medicet Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ James Shaffer	D 22836	1/22/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. James F. Shaffer, M.D. 501 North Frederick Avenue Gaithersburg, Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 26 2001	▶ Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Pierce
2. Date of Death: Month October Day 17, Year 2001
3. Time of Death: 2308 M
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 221-16-2495
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 75 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 27, 1926
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: MD
10b. County: Queen Anne's
10c. City, Town or Location: Grasonville
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 203 Gravel Run Road
10f. Zip Code: 21638
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse's Aide
18b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): John Lewis
18. Mother's Name (First, Middle, Maiden Surname): Rose Lee Green

19a. Informant's Name/Relationship (Type, Print): Michelle Coverdale
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2807 W. 3rd Street Wilmington, Delaware 19805

20a. Method of Disposition: 1☑ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Robinson's Church Cemetery
Date: 10/27/2001
20c. Location - City or Town, State: Grasonville, Maryland

21. Signature of Funeral Service Licensee: Janelle C. Henry
22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): Arteriosclerotic Cardiovascular Disease — Approximate Interval Between Onset and Death: years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A. Stout, M.D.
29c. License number: D06804
29d. Date signed (Month, Day, Year): 18 October 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David A. Stout, M.D. 219 S. Washington St., Easton, MD 21601

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001
32. Registrar's Signature: Jenna D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Elizabeth Pierce Feb 27 1926

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35439

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Barry David Richardson
2. Date of Death (Month, Day, Year): October 14, 2001
3. Time of Death: 1:55 AM
4a. Facility Name (If not institution, give street and number): 9024 Mountain Berry Court
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-48-6891
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 6, 1948
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9024 Mountain Berry Circle
10f. Zip Code: 21702
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self
16b. Kind of Business/Industry: painter/artist

17. Father's Name (First, Middle, Last): Harry Lamar Richardson, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Katherine Hines

19a. Informant's Name/Relationship (Type, Print): Shirley Richardson, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9024 Mountain Berry Circle, Frederick, MD 21702

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Brookhill Church Cemetery | Date: 10/18/2001
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Bergen M00999
22. Name and Address of Facility: Keeney and Basford Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Edema	1 week
Due to (or as a consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b. Astrocytoma	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D14236
29d. Date signed (Month, Day, Year): Oct 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PG Nausch MD 501 W 7th St Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year): OCT 17 2001
32. Registrar's Signature: Jennie D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35440

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Genevieve Hope Roberts		2. Date of Death (Month, Day, Year): October 20, 2001	3. Time of Death: 2:10 p.m.
4a. Facility Name (If not institution, give street and number): St. Mary's Nursing Center	4b. City, Town, or Location of Death: Leonardtown	4c. County of Death: St. Mary's	
5. Social Security Number: 215-22-6364	6. Sex: 1☐ M 2■ F	7. Age (In yrs. last birthday): 83 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 22, 1917	9. Birthplace (State or Foreign Country): West Virginia		

Usual Residence of Decedent

10a. State: Maryland	10b. County: St. Mary's	10c. City, Town or Location: Ridge	10d. Inside City Limits: 1☐ Yes 2■ No
10e. Street and Number: 16176 Murray Road	10f. Zip Code: 20680	10g. Citizen of What Country?: United States	

11. Marital Status: 1☐ Never Married 2☐ Married 3■ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2■ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2■ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Homer B. Jefferson

18. Mother's Name (First, Middle, Maiden Surname): Maude Mae Newman

19a. Informant's Name/Relationship (Type, Print): Norma Gene Ince / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11762 Point Lookout Road, Scotland, MD 20687

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5■ Other (Specify): Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Mausoleum

Date: 10-25-01

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Mary B. Rizzo MO1114

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dehydration

Due to (or as a consequence of):

c. leg gangrene

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Failure to Thrive

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D55027

29d. Date signed (Month, Day, Year): 24 October 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Manoj Panwala, M.D., 22576 MacArthur Boulevard, California, Maryland 20619

State Registrar

31. Date filed (Month, Day, Year): OCT 25 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35441

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hazel Virginia Russell
2. Date of Death (Month, Day, Year): October 18, 2001
3. Time of Death: 1:35 AM
4a. Facility Name *(If not institution, give street and number)*: Bayside Nursing Center
4b. City, Town, or Location of Death: Lexington Park
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 260-16-2576
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 14, 1921
9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 41376 Delabrooke Road
10f. Zip Code: 20659
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaar or Datas: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Front Desk Clerk
16b. Kind of Business/Industry: Hotel/Motel

17. Fathar's Name *(First, Middle, Last)*: John L. Watkins
18. Mother's Name *(First, Middle, Maiden Sumame)*: Rosie Monietta Bowen

19a. Informant's Name/Relationship *(Type, Print)*: Theresa Dobson Daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stata, Zip Code)*: PO Box 244 Mechanicsville MD 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or othar place)*: Mt. Zion UM Church Cemetery
Date: 10/23/01
20c. Location - City or Town, State: Mechanicsville Maryland

21. Signatura of Funaral Sarvice Licensee: Michael K. Gardiner
22. Name and Addrass of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part1 Enter the disease, or complications that caused tha death. Do not enter the moda of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in death)
a. Sepsis
Due to (or as a consequenca of):
b. Pneumonia
Due to (or as a consequenca of):
c.
Dua to (or as a consequanca of):
d.

Sequantially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
cerebrovascular accident, not acute

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John T. Fenwick
29c. License number: D01380
29d. Date signed *(Month, Day, Year)*: 10/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Fenwick 24035 Three Notch Road Hollywood MD 20636

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 23 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Taylor Rhodes, Sr.

2. Date of Death (Month, Day, Year): October 8, 2001

3. Time of Death: 8:53 AM

4a. Facility Name (If not institution, give street and number): St. Mary's Nursing Center

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 246-10-1214

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 17, 1912

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Leonardtown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 21580 Peabody Street

10f. Zip Code: 20650

10g. Citizen of What Country?: U S A

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondery (0-12): 3rd grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Caretaker

16b. Kind of Business/Industry: Camping Grounds

17. Father's Neme (First, Middle, Last): Harrison Rhodes

18. Mother's Name (First, Middle, Maiden Surneme): Arozing Jump

19a. Informant's Name/Relationship (Type, Print): John T. Rhodes, Jr. (Son)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 22284 Armstrong Drive, Leonardtown, Maryland 20650

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Ptace of Disposition (Neme of cemetery, cremetory or other plece): Brinsfield-Echols

Date: 10/9/2001

20c. Location - City or Town, State: Charlotte Hall , MD

21. Signature of Funeral Service Licensee: Mary Rizzo M01114

22. Name and Address of Facility: Brinsfield Funeral Home, P.A.
P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco uas contribute to the causs of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier:

29c. License number: D14285

29d. Date signed (Month, Dey, Year): 10-9-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyd, M.D. Leonardtown, Maryland 20650

State Registrar

31. Dete filed (Month, Day, Year): OCT 10 2001

32. Registrar's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35443

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HERBERT RICE
2. Date of Death: Month 10 Day 22 Year 2001
3. Time of Death: 630 P M
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 217-64-4380
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 45 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 8, 1956
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Eldersburg
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 834 Tonya Court
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Accounting

17. Father's Name (First, Middle, Last): Herbert George Rice, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Catherine Feeney

19a. Informant's Name/Relationship (Type, Print): Sharon Appleby/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8073 Forest Glen Drive Pasadena, MD 21122

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation, Inc.
Date: 10/24/2001
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Jeffrey N. Zumbrun
22. Name and Address of Facility: Jeffrey N. Zumbrun F.H. & Mon. Co. 6028 Sykesville Road Eldersburg, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 2 DAYS
Due to (or as a consequence of): CENTRAL LINE INFECTION — 3 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24e. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: 13150
29d. Date signed (Month, Day, Year): 10/22/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. N. PATWARDHAN 22 S GREENE ST BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35444

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
MARGARET	LOVISAH	RICHARDSON	Oct. 12, 2001	1:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mariner Health of Forest Hill	Forest Hill	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-24-5212	1☐M 2☒F	97 Yrs.			9/6/1904	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Harford	Jarrettsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1724 Jarrettsville Road	21084	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	6	School Teacher	Elementary School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Nelson Richardson	Margaret McClung

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Virginia R. Jackson/Niece	25 Lake Drive Bel Air, Maryland 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bethel Cemetery	10/15/2001	Madonna, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ M. Bladen Kurtz III	E.G. Kurtz Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Vascular Accident	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ David S Dunn	D32277	November 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David S Dunn 615 W. MacPhail

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 1 2001	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35445

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank P Sobus

2. Date of Death (Month, Day, Year): October 12, 2001

3. Time of Death: 10:30 A.m.

4a. Facility Name (If not institution, give street and number): Pleasant View Nursing Home

4b. City, Town, or Location of Death: Mt. Airy

4c. County of Death: Carrol

Funeral Director

5. Social Security Number: 217-14-9564

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 27, 1923

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1002 Long Corner Road

10f. Zip Code: 21771

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): longshoreman

16b. Kind of Business/Industry: commercial

17. Father's Name (First, Middle, Last): Pete Sobus

18. Mother's Name (First, Middle, Maiden Surname): Rose Malikowska

19a. Informant's Name/Relationship (Type, Print): Paul Gerad Sobus / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1002 Long Corner Road, Mt. Airy, MD 21771

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Hagerstown Crematory

Date: 10/13/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Jacqueline Krell

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 8 East Ridgeville Blvd., Mt. Airy, MD 21771

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BOWEL CARCINOMA — ~4YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [✓] Nursing Home 5 [ ] Residance 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: M.D.

29c. License number: D 24499

29d. Date signed (Month, Day, Year): 10-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Ronald Miller / 4 Culwell Drive, Mt. Airy, MD 21771

State Registrar

31. Date filed (Month, Day, Year): OCT 15 2001

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2001 35446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Smith
2. Date of Death: Month October Day 19 Year 2001
3. Time of Death: 1303 M
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 212-24-3208
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 17,22
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 9615 Liberty Road
10f. Zip Code: 21701
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Proprietor
16b. Kind of Business/Industry: Plumbing / Heating

17. Father's Name (First, Middle, Last): Charles Benjamin Long
18. Mother's Name (First, Middle, Maiden Surname): Bessie Sarah Fritz

19a. Informant's Name/Relationship (Type, Print): Robert D. Long/ son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10321 Old Annapolis Rd./ Walkersville, MD 21793

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Mem.Garden
Date: 10/23/2001
20c. Location - City or Town, State: Frederick,Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson
22. Name and Address of Facility: Stauffer Funeral Home 1621 Opossumtown Pike / Frederick,MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — Approximate Interval Between Onset and Death: 3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic renal insufficiency
Atrial fibrillation

23e. Did tobacco use contribute to the causa of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Nimalie Stone MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): October 19, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nimalie Stone Johns Hopkins Hospital Tower 110 Doctors Lounge 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): OCT 22 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be completed by Funeral Director: permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James E. Shilling Sr.	October 23 2001	2:30p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-36-7243	1☒M 2☐F	66 Yrs.			Feb. 19,1935	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Damascus	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
25101 Angela Court	20872	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1953-67	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Salesman	Auto

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Mark Tinsley	Mary Virginia Jenkins

19a. Informant's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James E. Shilling Jr./ Son	25101 Angela Court, Damascus, Maryland 20872

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☒Other (Specify) Intombment	Resthaven Memorial Gardens	Oct 26,2001	Frederick, Maryland

21. Signature of Funeral Service Licensee: Todd A Wyne

22. Name and Address of Facility: Olin L. Molesworth P. A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finel disease or condition resulting in death)	a. Cardio- Pulmonary Arrest	Within an hour
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or es e consequence of): b. Ventricular Fibrillation	6 months to a year
	Due to (or as a consequence of): c. Ischimic Cardiomyopathy	
	Due to (or as a consequence of): d. Coronary Artery Disease	

IF FEMALE: 23b. Was decedent pregnant in the pest 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant et time of deeth 5☐Other (specify) _____ 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status Post Coronary Artery Bypass Surgery and Defibrillator

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, fann, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Murmarka MD	D29816	October 24, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RADHEY MURARKA. 50 W Edmonston Drive Rockville, Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 26 2001	Teresa D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35448

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stanley Alphonse Sito
2. Date of Death (Month, Day, Year): October 24, 2001
3. Time of Death: 11:18AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-16-3200
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 18, 1920
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6897 Buttonwood Court
10f. Zip Code: 21703
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): I
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manufacturing Engineer
18b. Kind of Business/Industry: Aircraft Company

17. Father's Name (First, Middle, Last): Jan Sito
18. Mother's Name (First, Middle, Maiden Surname): Annie Drag

19a. Informant's Name/Relationship (Type, Print): Madeleine Sito (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6897 Buttonwood Court, Frederick, MD 21703

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: 10/29/01
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Valvular Heart Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Adenocarcinoma of Lung

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Casper E. Cline MD
29c. License number: D16428
29d. Date signed (Month, Day, Year): 10/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline, III, 300 West 9th Street, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): OCT 26 2001
32. Registrar's Signature: Penny B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35449

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Eugene Charles Stamnos
2. Dete of Death (Month, Day, Year): October 13, 2001
3. Time of Death: 2:30 AM
4a. Facility Neme (If not institution, give street end number): 21722 St. Lo Place
4b. City, Town, or Location of Death: Lexington Park
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 219-48-5841
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 11, 1947
9. Birthplace (Stete or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 21722 St. Lo Place
10f. Zip Code: 20653
10g. Citizen of Whet Country?: U S A

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12); College (1-4or 5+): 2 years
16e. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired): Quality Control Officer
16b. Kind of Business/Industry: Civil Service

17. Fether's Name (First, Middle, Last): Paul Charles Stamnos
18. Mother's Name (First, Middle, Meiden Surneme): Shirley Ann McDonald

19a. Informent's Neme/Relationship (Type, Print): Shirley M. Stamnos (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21722 St. Lo Place, Lexington Park, Maryland 20653

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): St. George Episcopal
Date: 10/17/01
20c. Location - City or Town, State: Valley Lee, Maryland

21. Signeture of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Fecility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. Carcinomatosis — 6 wks

Due to (or as a consequence of):
b. Rectal Cancer — 6 mo.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting tn death) Lest

Due to (or as e consequence of):
c.

Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homtcide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner stetes.

29b. Signeture end title of certifier: J. Patrick Jarboe M.D.
29c. License number: D 06419
29d. Date signed (Month, Day, Year): 10-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Patrick Jarboe, M.D. Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year): OCT 19 2001
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35450

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jeanette (nmn) Staley
2. Date of Death (Month, Day, Year): October 26, 2001
3. Time of Death: 7:50 PM
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 257-17-1089
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 40 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 30 1961
9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Hollywood
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 25043 Gallant Man Drive
10f. Zip Code: 20636
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cook
16b. Kind of Business/Industry: Restaurant

17. Father's Neme *(First, Middle, Last)*: Edward McQueen
18. Mother's Name *(First, Middle, Maiden Surneme)*: Leola Brown

19a. Informent's Neme/Reletionship *(Type, Print)*: Carl Eldridge Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6551 McGlachin Ave Lawton OK 73501

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Ptece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory
Date: 10/30/01
20c. Location - City or Town, Stete: Alexandria Virginia

21. Signature of Funeral Service Licensee: Michael K. Gardiner
22. Name end Address of Fecility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death): e. COLON CANCER — 3yrs

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier
29c. License number: D34539
29d. Date signed *(Month, Day, Year)*: 10.29.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khalid Husain 22576 MacArthur Blvd. California MD 20619

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 29 2001
32. Registrer's Signeture

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

2

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35451

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David Lee Scott

2. Date of Death Month Day Year: October 15, 2001

3. Time of Death: 4:39 PM

4a. Facility Name *(If not institution, give street and number)*: 22580 Old Rolling Road

4b. City, Town, or Location of Death: California

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 217-72-9894

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 20, 1958

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: California

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 22580 Old Rolling Road

10f. Zip Code: 20619

10g. Citizen of What Country?: U S A

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Home Building

17. Father's Name *(First, Middle, Last)*: Douglas Lee Scott

18. Mother's Name *(First, Middle, Maiden Surname)*: Patricia Ann Lacey

19a. Informant's Name/Relationship *(Type, Print)*: Patricia A. Scott (Mother)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 22580 Old Rolling Road, California, Maryland 20619

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Immaculate Heart of Mary

Date: 10/19/01

20c. Location - City or Town, State: Lexington Park, MD

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, JR. M00052

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Terminal Lung Cancer

Due to (or as a consequence of):

Brain Metastasis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Roy H. Bunales, M.D.

29c. License number: D21893

29d. Date signed *(Month, Day, Year)*: 10/18/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Roy H. Bunales, M.D. Lexington Park, Maryland 20653

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 22 2001

32. Registrar's Signature: Donna B. Sparks

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ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35452

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: William Leo Scriber

2. Dete of Death Month: October Dey: 15 Year: 2001

3. Time of Death: 10:10 AM

4a Facility Name *(If not Institution, give street and number)*: 24934 Sotterly Road

4b. City, Town, or Location of Death: Hollywood

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 220-16-8743

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Jan. 12, 1929

9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Hollywood

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 24934 Sotterly Road

10f. Zip Code: 20636

10g. Citizen of What Country?: U S A

11. Meritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Giva Yaar or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Bieck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician

16b. Kind of Business/Industry: Civil Service

17. Fathar's Nama *(First, Middla, Last)*: James Edward Scriber

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Mary Gertrude Barber

19e. Informant's Neme/Reletionship *(Type, Print)*: Judy Hubbard (Daughter)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 24934 Sotterly Road, Hollywood, Maryland 20636

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Ramoval from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or othar piece)*: Immaculate Heart of Mary

Dete: 10/20/01

20c. Location - City or Town, Stete: Lexington Park, MD

21. Signeture of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052

22. Name end Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death)

e. Metastatic carcinoma — 03/01.

Due to (or es a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest

b. Adenocarcinoma type c

Due to (or es e consequenca of):

c. primary probably Pancreas

Due to (or es e consequence of):

d.

Pert II. **Other signiticant conditions** contributing to death but not resulting in the underlying cause given in Pert t.: COPD. asthma

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings avellable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Placa of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Homeli

29c. License number: D36206

29d. Date signed *(Month, Dey, Year)*: 10/17/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): KERAN MEHTA HOLLYWOOD MD 20636

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 19 2001

32. Registrer's Signature: D. Smith

ORIGINAL

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Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35453

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Madeline Sauble
2. Date of Death: Month 10 Day 21 Year 2001
3. Time of Death: 0915
4e. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-07-0889
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07 29 1918
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 205 St. Mark Way
10f. Zip Code: 21158
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): John L. Storms
18. Mother's Name (First, Middle, Maiden Surname): Mamie Dickensheets

19a. Informant's Name/Relationship (Type, Print): Judy Waters/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Victoria Court Reisterstown, MD 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Leisters Cemetery
Date: 10/24/2001
20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

HYPERTENSION

PULMONARY EDEMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D0050763
29d. Date signed (Month, Day, Year): 10/22/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ERNESTO MENDOZA, M.D. 6846 POOLE RD. WESTMINSTER, MD 21157

State Registrar

31. Date filed (Month, Day, Year): OCT 23 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

HELEN MADELINE SAUBLE

WJZ 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. # 2001 35454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Charles William Sechrist, Sr.	Oct 23 2001	0910 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Carroll County General Hospital	Westminster	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-01-5624	1☒M 2☐F	85 Yrs.			Dec 24 1915	W VA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Westminster	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
520 Tremont Drive	21157	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Yeer or Detes: 1941 1945	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Salesman	Greenspring Dairy

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Forrest Bell Sechrist	Edith Pearl Shaull

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Beverly Ann Sechrist/wife	520 Tremont Drive Westminster, MD 21157

20e. Method of Disposition	20b. Pleca of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lorraine Park Cem	10/26/2001	Baltimore, MD

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth)	a. metastatic esophageal cancer	6 mos.
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last	b. Due to (or as e consequence of):	
	c. Due to (or es e consequenca of):	
	d. Due to (or as e consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☑Unknown

24a. Wes en autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one)
Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and *manner* es steted.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end *manner* stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D40850	October 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
YVONNE OTTAVIANO MD 555 Center St. Westminster Md 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 24 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

WJ 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar: Amend Item#23a perPHYG801 11/06/01 EW

Certificate of Death

Reg. No. 2001 35455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JUDY ANN SHADE	OCTOBER 20 2001	7:43 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CIVISTA MEDICAL CENTER	LAPLATA	CHARLES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-80-5575	1 M 2 X F	44 Yrs.			June 11,1957	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Charles	La Plata	X 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11851 Lizzy's Place	20646	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Certified Nursing Asst.	Nursing Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Wade Cole,Sr.	Mary Beatrice Thomas Cole

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Christopher Cole/Son	6154 Sea Lion Pl. Waldorf,MD. 20603

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Brinsfield-Echols	10/26/01	Charlotte Hall,MD.

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
David C. Echols	M00945	AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	~~Asphyxia~~ ACUTE HEMOPTYSIS	< 15 Minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): METASTATIC LUNG CANCER	
	b. Due to (or as a consequence of): ~~Acute Hemoptysis~~	
	c. Due to (or as a consequence of): ~~Metastatic Lung Cancer~~	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 Yes 2 X No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 ✓ No	1 ✓ Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 ✓ No	Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ✓ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ✓ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Song Chon M.D.	D 37174	10/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SONG C. CHON MD

CENNA MEDICAL CENTER 7C POST OFFICE ROAD WALDORF MD 20602

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 24 2001	Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JUDY SHADE
CHARLES
23A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend item#23a perPHYG801 11/06/01 EW

Certificate of Death

Reg. No: 2001 35456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
DANIEL	THOMAS	STATEN,JR.	October 1, 2001	1930

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Memorial Hospital	Easton	Talbot

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-20-7873	1☒ M 2☐ F	72 Yrs.			Oct.27,1928	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Caroline	Denton	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
525 High Street	21629	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
11		Truck Driver	Messick Truck Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Daniel T. Staten,Sr.	Elsie Pinkett

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sarah Staten, Wife	525 High Street, Denton,Maryland 21629

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Maryland Veterans Cem.	10/9/01	Beulah,Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility
Bennie Smith Funeral Home
426 Dover Street, Easton,Maryland 21601

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Daniel Staten
Baltimore, Maryland 21215-0020

TALBOT 230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal Failure

Due to (or as a consequence of):
b. Partial rejection cadaveric transplant

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. CARDIOMYOPATHY

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis DeShield	D0053110	10/7/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Dennis DeShield, 219 Washington Street, Easton,Maryland 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 04 2001	Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35457

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Alan	Joseph	Thompson	October	14	2001	2:52 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-52-8633	1 [X] M 2 [ ] F	63 Yrs.			March 1, 1938	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Ijamsville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2296 Persimmon Drive	21754	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Company President	Industrial Equip/Supply

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Allie Clarendon Thompson	Helen E. Thompson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Thompson, wife	2296 Persimmon Drive, Ijamsville, MD 21754

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Smithsburg Crematory	Oct. 15, 2001	Smithsburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ryan M. Berger MO0999	Keeney and Basford Funeral Home 106 East Church Street, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral hemorhage	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A.Z. HEGAZI, MD	D44184	10-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
801 TOLLHOUS Ave, Bld F, Frederick MD 21701 - A.Z. HEGAZI, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 2001	▶ Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35458

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEFF TANNER
2. Date of Death: Month OCTOBER Day 15 Year 2001
3. Time of Death: 1935
4a. Facility Name (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 248-54-8220
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 3, 1936
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: California
10b. County: Ventura
10c. City, Town or Location: Ventura
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 6500 Telephone Road - 302
10f. Zip Code: 93003
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Vietnam
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: White

15. Decedent's Eductian (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Auto

17. Fathar's Nema (First, Middla, Last): Clyde G. Tanner
18. Mother's Neme (First, Middle, Meiden Surname): Lucille Prince

19a. Informant's Neme/Reletionship (Type, Print): Jerry Tanner - Brother
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 21910 Huntmaster Drive, Gaithersburg, Maryland 20882

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery
Dete: 10/31/01
20c. Location - City or Town, Stete: Arlington, Virginia

21. Signature of Funerel Service Licensee: Olin L. Molesworth
22. Nama end Address of Facility: Olin L. Molesworth P.A., Funeral Home, 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications thet causad tha daath. Do not antar tha mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line. Approximete Interval Between Onsat end Death

Immediate Ceuse (Final disease or condition resulting in deeth): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events rasulting in death) Lest:
b.
Due to (or es e consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Piece of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Spacify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, daath occurred et the time, date end piece, end due to the ceuse(s) end menner as steted. 2 [X] **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: MD (OME)
29c. Licansa number: D15236
29d. Data signed (Month, Day, Year): OCTOBER 15, 2001

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): CARL I. MARGOLIS, M.D. (OME) 11125 Rockville Pike, Rockville, MD 20852

State Registrar

31. Dete filed (Month, Day, Year): OCT 22 2001
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35459

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irene Maude Twiss
2. Date of Death (Month, Day, Year): October 12, 2001
3. Time of Death: 11:10 AM
4a. Facility Name (If not institution, give street and number): St. Mary's Nursing Center
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 578-22-2098
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 25, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Callaway
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 20749 Point Lookout Road
10f. Zip Code: 20620
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Harry Hamilton Raley
18. Mother's Name (First, Middle, Maiden Surname): Rose Maria Price

19a. Informant's Name/Relationship (Type, Print): Harry C. Raley Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 44710 Medleys Neck Rd. Leonardtown MD 20650

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Immaculate Heart of Mary Cem.
Date: 10/16/01
20c. Location - City or Town, State: Lexington Park MD

21. Signature of Funeral Service Licensee: Michael Kevin Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Failure to thrive

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Organic Brain Syndrom.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D Shah
29c. License number: D 47066
29d. Date signed (Month, Day, Year): 10-15-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Avani D Shah St. Mary's Medical Arts Bldg. Leonardtown MD 20650

State Registrar

31. Date filed (Month, Day, Year): OCT 16 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#26 perVERBALG801 11/06/01 EW

Certificate of Death

Reg. No. 2001 35460

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Year	3. Time of Death
Edward Louis Talley	October 9, 2001	1:00 a.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
606 Cox Saw Mill Road	Centreville	Queen Anne's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-30-1401	1☒M 2☐F	54 Yrs.			October 24, 1946	Delaware

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Queen Anne's	Centreville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
606 Cox Sawmill Road	21617	USA

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americen Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1968-1970	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Carpenter/Builder	Building

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Owen Matthew Talley	Helen Eleanor Prinski

19a. Informant's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sharon Talley/ Wife	606 Cox Saw Mill Road, Centreville, Maryland 21617

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sudlersville Cemetery	10/12/2001	Sudlersville, MD

21. Signature of Funerel Service Licensee	22. Name and Address of Facility
▶ [signature]	Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23e. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediete Ceuse (Finel disease or condition resulting in deeth)	e. Hepatocellular CA	4mths
	Due to (or es e consequence of):	
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Cirrohosis of liver	4mths
	Due to (or es e consequence of):	
	c. Hepatic encephalopathy	4mths
	Due to (or as a consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Type II DM
Hypertension

23b. Did tobacco use contributa to tha causa of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was cese referred to medical exeminer?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) ~~Home~~ Hospice

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and menner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Valerie Goodman DO	H0057921	10/10/01

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)
VALERIE Goodman, D.O., 2540 Centreville Rd, Centreville, MD 21617

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
OCT 11 2001	▶ [signature] G. Sparks

State Registrar

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 + 1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35461

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mazie Lee Van Sise

2. Date of Death Month Day Year: October 2, 2001

3. Time of Death: 10:15 AM

4e Facility Name *(If not institution, give street end number)*: Solomon's Nursing Center

4b. City, Town, or Location of Death: Solomons

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 217-44-6805

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 29, 1906

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Hollywood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 43616 St.John's Road

10f. Zip Code: 20636

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Benjamin Franklin Byron

18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Long Curtis

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Lee Dillow Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 43616 St. John's Road Hollywood MD 20636

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Joy Chapel Cemetery

Date: 10/5/01

20c. Location - City or Town, State: Hollywood Maryland

21. Signature of Funeral Service Licensee: [signature] M01206

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. myocardial infarction

Due to (or as a consequence of):

b. atherosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D43306

29d. Date signed *(Month, Day, Year)*: 10/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sylvia Batong 11845 HG Trueman Road Lusby MD 20657

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 04 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-5560-037
mnmr
Lewis Harold Wood

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lewis Harold Wood, Jr.
2. Date of Death (Month, Day, Year): September 29, 2001
3. Time of Death: 1934 pm
4a. Facility Name (If not institution, give street and number): 23866 Leonardtown Hollywood Road
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 218-13-7346
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 30 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 7, 1970
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 23866 Leonardtown Hollywood Rd
10f. Zip Code: 20650
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Automobile Transport

17. Father's Name (First, Middle, Last): Lewis Harold Wood, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Jeannette Adams

19a. Informant's Name/Relationship (Type, Print): Jeannette Adams Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15455 Sorrel Ridge Lane Waldorf MD 20601

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Memorial Gardens
Date: 10/3/01
20c. Location - City or Town, State: Waldorf Maryland

21. Signature of Funeral Service Licensee: [signature] 10/1/2001
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HANGING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? INVESTIGATION 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [✓] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28c. Injury at Work? 1 [ ] Yes 2 [✓] No

28b. Time of Injury: 1934 P M

28e. Date of Injury (Month, Day, Year): 9-29-01

28d. Describe how injury occurred: SUSPECT HANGED SELF

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 23866 HOLLYWOOD RD ST MARYS CO

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): September 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANNE A. KOROL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT - 2 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35463

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edwin Alan Wyland

2. Data of Death Month Day Year: October 16, 2001

3. Time of Death: 2:45 AM

4a Facility Name *(If not institution, give street and number)*: 20857 Ark Court

4b. City, Town, or Location of Death: Lexington Park

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 206-40-3484

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 51 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 24, 1950

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedant

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Lexington Park

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 20857 Ark Court

10f. Zip Coda: 20653

10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: 1 [ ] Navar Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedant Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12) / Collega (1-4or 5+): 2

16a. Decedant's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa retired)*: Mine Maintenance Supervisor

16b. Kind of Businass/Industry: Mining

17. Father's Name *(First, Middle, Last)*: Oliver Wyland

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Ivory Noble

19a. Informant's Name/Ralationship *(Type, Print)*: Donna Jane Wyland Wife

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 20857 Ark Court Lexington Park MD 20653

20a. Mathod ot Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donatlon 5 [ ] Othar *(Specify)*

20b. Place ot Disposition *(Nama of cematary, crematory or othar placa)*: Ruffner Cemetery

Data: 10/20/01

20c. Location - City or Town, Stata: Rayne Township, PA

21. Signatura of Funaral Service Licensee: [signature] 10/20/06

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that ceused tha daath. Do not antar tha moda ot dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only ona cause on aach lina.

Approximata Intarval Batween Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in daath)

e. Metastatic Colon Cancer — 4 mos

Due to (or as a consequanca ot):

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in daath) Last.

b.

Due to (or as a consequance ot):

c.

Due to (or as a consequanca ot):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] **Yes** 2 [X] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to complation of ceusa of death? 1 [ ] Yas 2 [X] No

25. Wes casa ratarred to medical axaminar? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [X] Residence 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Data ot Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Place ot Injury - At homa, tarm, streat, factory, office building, atc. *(Specify)*

28t. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician:** To tha best ot my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceuse(s) and mannar stated.

29b. Signature and title of certifier: [signature]

29c. Licanse number: D34184

29d. Date signed *(Month, Day, Year)*: 10/16/01

30. Name end addrass of person who complated ceusa of daath (Itam 23a) (Type, Print): David Federle 20435 Three Notch Road Hollywood MD 20636

State Registrar

31. Data filad *(Month, Day, Year)*: OCT 19 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2001 35464
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Mack Wright
2. Date of Death Month Day Year: October 4, 2001
3. Time of Death: 9:35A M
4a. Facility Name (If not institution, give street and number): 2210 Pelham Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 110-14-8935
6. Sex: 1☐M 2■F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 13, 1918
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1■Yes 2☐No
10e. Street and Number: 2210 Pelham Avenue
10f. Zip Code: 21213
10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3■Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2■No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2■No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John William Mack
18. Mother's Name (First, Middle, Maiden Surname): Jennie Peterson

19a. Informant's Name/Relationship (Type, Print): Joan E. O'Brien / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22882 Piney Wood Circle, California, Maryland 20619

20a. Method of Disposition: 1■Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Cemetery
Date: 10-08-2001
20c. Location - City or Town, State: Hollywood, Maryland

21. Signature of Funeral Service Licensee: Mary B. Rizzo R133 M01114
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
Cerebrovascular disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)
27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert Y Hsiao MD
29c. License number: D35305
29d. Date signed (Month, Day, Year): 10-04-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Y Hsiao MD 5601 Loch Raven Blvd BALT. MD.

State Registrar

31. Date filed (Month, Day, Year): OCT 09 2001
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35465

EILEEN WOOD

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Eileen Louise Wood	OCT 21 2001	1044 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL	EASTON	TALBOT

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-38-9653	1☐ M 2☒ F	61 Yrs.			Jul.4,1940	BaltimoreMD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Caroline	Preston	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7360 Todds Wharf Road	21655	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Office Work	Printing/Health

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Louis Kreczmer	Agatha Rosile Frankewicz

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Teresa Liszewski/Daughter	6591 Harmony Road, Preston, MD 21655

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cambridge Crem.	10/22/01	Cambridge, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael J. Eskow	Framptom-Hawkins-Eskow Funeral F. Home Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Breast CA with Metastatic Disease

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. End Stage Renal Disease & Hemodialysis

Due to (or es a consequence of):

c. Diabetes mellitis with diabetic retinopaty

Due to (or as a consequence of):

d. Incarcerated ventral hernia

IF FEMALE: 23b. Was decedent pregnent in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No	26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examinar:** On the besis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Valene Gudmen	H0057821	10/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

2540 Centreville Road, Centreville MD 21617.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 22 2001	▶ Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 26e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Caroline 930

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35466

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES HOYLE WEAVER

2. Date of Death (Month, Day, Year): OCTOBER 22, 2001

3. Time of Death: 6:15 PM

4a. Facility Name *(If not institution, give street and number)*: 811 FAIRFIELD AVENUE

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 213-36-8870

6. Sex: XXX M 2☐ F

7. Age *(In yrs. last birthday)*: 96 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUGUST 3, 1905

9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CARROLL

10c. City, Town or Location: WESTMINSTER

10d. Inside City Limits: 1☐ Yes XX No

10e. Street and Number: 315 MARY AVENUE

10f. Zip Code: 21157

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married X☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2XX No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DAIRY FARMING

16b. Kind of Business/Industry: DAIRY

17. Father's Name *(First, Middle, Last)*: WILLIAM GRANVILLE WEAVER

18. Mother's Name *(First, Middle, Maiden Surname)*: LULU MEDLEY

19a. Informant's Name/Relationship *(Type, Print)*: WILLIAM L. WEAVER/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 315 MARY AVENUE, WESTMINSTER, MD 21157

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MEADOW BRANCH CEMETERY

Date: 10/25/01

20c. Location - City or Town, State: WESTMINSTER, MD

21. Signature of Funeral Service Licensee: Susan Flaherty Myers

22. Name and Address of Facility: MYERS FUNERAL HOME, 91 WILLIS STREET, WESTMINSTER, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — 25yr

Due to (or as a consequence of): b. advanced age — 96yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2X No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2X No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6X Other *(Specify)* Assisted Living

27. Manner of Death: 1X Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred: Living

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Middleton

29c. License number: D25443

29d. Date signed *(Month, Day, Year)*: 10-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN W. MIDDLETON M.D. 688 POOLE RD, WESTMINSTER, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 23 2001

32. Registrar's Signature: Donna B Sparks

WJR 1

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35467

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DAVID HOMER WOOZLEY	October 13, 2001	12:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Northampton Manor Nursing Home	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
210-14-5346	1 [X] M 2 [ ] F	76 Yrs.			June 10, 1925	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
200 East 16th Street	21701	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Salesman	Lab Supplies

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
David Homer Woozley, Sr.	Margaret Louise Davis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edna Woozley (Wife)	6886 Arbor Court, Frederick, Maryland 21703

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Resthaven Mem. Gardens	10/16/01	Frederick, Maryland

21. Signature of Funeral Service Licensee ▶ Robert E. Dailey Jr.

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. pneumonia	1 wks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. stroke	years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Casper E. Cline III MD	D 16428	10/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline, III, MD 300 West 9th Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 15 2001	▶ Bonnie G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Edna Wooxley (Wife)	6886 Arbor Court, Frederick, Maryl		
David Homer Wooxley, Sr.	Margaret Louise Davis	4	Salesman	Lab Supplie
		WWII	X	White

X

Restbaven Mem. Gardens 10/16/01 F

ROBERT E. DAILEY & SON F
1201 NORTH MARKET ST.,

Pneumonic
Stroke

X
X
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35468

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Catherine Whitehead
2. Date of Death (Month, Day, Year): October 15, 2001
3. Time of Death: 8:50 AM

4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Home
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-66-3985
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 4, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Adamstown
10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5908 Lawrence Court
10f. Zip Code: 21710
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Louis Easterday
18. Mother's Name (First, Middle, Maiden Surneme): Carrie Whipp

19a. Informent's Name/Relationship (Type, Print): Mrs. Joyce Crawford, Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 8713 Antietam Drive, Walkersville, Maryland 21793

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): St. Pauls Cemetery, Oct.
Date: 17, 2001
20c. Location - City or Town, State: Point of Rocks, Md.

21. Signature of Funeral Service Licensee: ▶ Richard E. Graf M00255
22. Name end Address of Facility: Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause in each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hepatic Oxsides	1 week
Due to (or as a consequence of): b.	Cerebrovascular accident	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — Due to (or es a consequence of): c.		
Due to (or es a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Subarachnoid hemorrhage

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Pieca of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Francis E. Decker MD
29c. License number: D30496
29d. Date signed (Month, Dey, Year): October 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francis E. Decker MD; 300 W 5th St; Frederick Md 21701

State Registrar

31. Date filed (Month, Dey, Year): OCT 16 2001
32. Registrar's Signature: ▶ Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35469

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JULIA	MCCARTHY	WOOD	OCTOBER 24, 2001	4:45 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CITIZEN'S NURSING HOME	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
186-14-7072	1☐ M 2☒ F	81 Yrs.			January 1,1920	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
417 Dauphine St.	20906	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Michael McCarthy	Mabel Lever

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Peter Wood / son	4504 Granite Dr./ Middletown, Maryland 21769

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hagerstown Crematory	10/25/2001	Hagerstown,Maryland

21. Signature of Funeral Service Licensee ▶ Paul T. B. Markey

22. Name and Address of Facility STAUFFER FUNERAL HOMES, P.A. 1621 OPOSSUMTOWN PIKE, FREDERICK, MD 21702

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	3yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert L Kaufmann	D-13971	10/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert Kaufmann, 300 W. 9th St./ Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 26 2001	▶ Jennie G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35470

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
DENA MARIE ABATO			NOV. 5, 2001	1 PM M
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
2012 W. ROGERS AVE	BALTO.		N/A	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-07-2028	1 M 2 F	90 Yrs.			MARCH 4, 1911	ITALY

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2012 W. ROGERS AVE	21209	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	NONE	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
NICHOLAS COLLEVECCHIO	MARIETTE DEGIOVANNI

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANTHONY ABATO (SON)	2012 W. ROGERS AVE BALTO. MD. 21209

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	HOLY REDEEMER CEM	11/9/01	BALTO. MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	DELANOE & SONS FUNERAL HOME 322 S. HIGH ST. BALTO MD. 21202

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO-PULMONARY ARREST

Due to (or as a consequence of):

b. CONGESTIVE HEART FALURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 4 YRS

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Howard B. Cohen MD	D21680	11/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

677 PARK HEIGHTS AVENUE BALTIMORE, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35471

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Gertrude Yvon Bizzarri	November 4, 2001	10:25 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3511 Wilkens Avenue	Baltimore	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212--10-4987	1☐M 2☒F	84 Yrs.			July 5, 1917	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	n/a	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3511 Wilkens Avenue	21229	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Seamstress	Raincoat

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Linwood Handley	Lena Hill

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janet Kassakatis - Daughter	3511 Wilkens Avenue, Baltimore, Maryland 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Baltimore National	Nov. 8,2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶ Ann G. Zink

22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. DEHYDRATION	2 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. MICROSCOPIC COLITIS	ONE MONTH
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE
PERIPHERAL VASCULAR DISEASE
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Seth Rest MD	D40012	NOVEMBER 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SCOTT POULTON, 700 GEIPE ROAD, CATONSVILLE MD 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	Denise D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35472

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Magaline	Butler	OCTOBER, 28 2001	2230 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. AGNES HEALTH CARE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
257-30-8098	1☐M 2☒F	87 Yrs.			MAR. 18, 1914	Georgia

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Elkridge	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6391 Rowanberry Court, Apt. 3	21075	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th		Nurses Aide	Healthcare

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Anderson John Crow	(Unavailable)

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anita Bennett - daughter	3306 Mueller St., Balto., Md. 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	Meadowridge Mem. Park	10/30/01	Elkridge, Md.

21. Signature of Funeral Service Licensee: ▶ Mark E. Marshall

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Congestive Heart failure — Due to (or as e consequence of): — Months

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as e consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel deeth 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Resident	P13599	Oct 28 2001

30. Name and address of person who completed cause of death (Item 23a) (Type. Print): Michael Steffie 900 caton Ave Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): NOV 07 2001

32. Registrar's Signature: George B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Butler MA Galine

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35473

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Helen Bock

2. Date of Death Month / Day / Year: Nov. 4 2001

3. Time of Death: 8:20am

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-28-3614

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 20 1929

9. Birthplace *(State or Foreign Country)*: MAryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Perry Hall

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9530 Perry Hall Blvd.

10f. Zip Code: 21236

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8th — College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Management

16b. Kind of Business/Industry: C&P Telephone

17. Father's Name *(First, Middle, Last)*: William Kelly

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Mable Crowley

19a. Informant's Name/Relationship *(Type, Print)*: Ernest Garner

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 12908 Dulaney Valley Road GlenArm MD21057

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: HolyRedeemer — Date: 11/8/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. laryngeal cancer — months

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or es e consequenca of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: lung cancer

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other *(Specify)* hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D0051926

29d. Date signed *(Month, Day, Year)*: November 4, 2001

30. Name snd address of person who completed cause of death (Item 23a) (Type, Print): Helen M Gordon 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 07 2001

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Bock, Mary 11/4/01 8:20am

RR 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35474

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLENN Thomas BONDURANT

2. Data of Death Month Day Yaar: November 04 2001

3. Tima of Daath: 1340 M

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Daath: Baltimore City

4c. County of Daath:

Funeral Director

5. Social Security Number: 215-68-3737

6. Sex: 1☒M 2☐F

7. Aga (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): 2-23-62

9. Birthplaca (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. Stata: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒Yas 2☐No

10e. Street and Number: 900 W. 37th St. 2nd flr.

10f. Zip Coda: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Navar Marriad 2☐Marriad 3☐Widowad 4☐Divorcad

12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Deli Asst. Manager

18b. Kind of Businass/Industry: Supermarket.

17. Fathar's Nama (First, Middle, Last): Glenn Thomas Bondurant, SR.

18. Mothar's Nama (First, Middle, Maidan Surname): Eleanor Snell

19a. Informant's Name/Relationship (Type, Print): Mother Eleanor (Snell) Bondurant

19b. Mailing Addrass (Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda): 1041 Kenilworth DR. Towson MD 21204

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stata 4☐Donation 5☐Othar (Specify)

20b. Placa of Disposition (Nama of cametary, crematory or other placa): Dulaney Valley Mem Gardens Data: 11-8-01

20c. Location - City or Town, Stata: Timonium MD

21. Signatura of Funaral Sarvica Licansaa: Krista J. Wells

22. Nama and Addrass of Facility: Timonium MD 21093 EVANS Funeral Chapel 2325 York Rd.

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the death. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one causa on aach line.

Approximata Intarval Batwaan Onsat and Death: 37 years

Immadiata Cause (Final disaasa or condition rasulting in daath): a. Pulmonary Hypertension

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last:

b. Dua to (or as a consaquanca of):

c. Dua to (or as a consaquanca of):

d. Dua to (or as a consaquanca of):

IF FEMALE:

23b. Was decadant pregnant in tha past 12 months? 1☐Yas 2☐No 9☐Unknown

23c. If yas, outcoma of pregnancy: 1☐Livа birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Othar (specify) 9☐Unknown

23d. Data of dalivary Month Day Yaar

Part II. **Othar significant conditions** contributing to daath but not resulting in tha undarlying causa givan in Part I.

23e. Did tobacco usa contributa to tha causa of daath? 1☐Yas 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performad? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to compliation of causa of daath? 1☐Yas 2☐No

25. Was casa rafarrad to madical examinar? 1☐Yas 2☒No

28. Placa of Death (Check only one): Hospital: 1☒Inpatiant 2☐ER/Outpatiant 3☐DOA Other: 4☐Nursing Homa 5☐Rasidanca 6☐Othar (Specify)

27. Manner of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined

28e. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describa how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒**Cartifying Physician:** To tha bast of my knowladga, daath occurrad at tima, data and placa, and dua to tha causa(s) and manner as statad. 2☐**Madical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, data and place, and dua to tha causa(s) and manner statad.

29b. Signatura and titla of cartifiar: M Brad Drummond, MD

29c. Licansa number: Res-000

29d. Data signad (Month, Day, Yaar): November 4, 2001

30. Nama and addrass of parson who completad causa of daath (Itam 23a) (Type, Print): M. Brad Drummond, M.D. Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD Tower 110, Doctors Lounge 21287

State Registrar

31. Data filad (Month, Day, Yaar): NOV 07 2001

32. Registrar's Signatura: Bryan D Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 10

DHMH 17 Rev 1/2001

ORIGINAL.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35475

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES W. BECKWITH

2. Date of Death — Month: November Day: 5 Year: 2001

3. Time of Death: 12:00 AM

4a. Facility Name (If not institution, give street and number): VAMHCS - Fort Howard Division

4b. City, Town, or Location of Death: Fort Howard

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-36-5283

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 14, 1924

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No XX

10e. Street and Number: 2113 W. LEXINGTON ST.

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced XX

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: 43-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) — Elamentary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): AUTO MECHANIC

16b. Kind of Business/Industry: AUTO

17. Father's Name (First, Middle, Last): JAMES T. BECKWITH

18. Mother's Name (First, Middle, Maiden Surname): LOTTIE OLIVIA BRADFORD

19a. Informant's Name/Relationship (Type, Print): SYLVIA BECKWITH/WIFE

19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code): 2113 W. LEXINGTON ST., BALTO., MD 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify) XX

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): CROWNSVILLE VET. CEM.

Date: 11/13/01

20c. Location - City or Town, State: CROWNSVILLE, MD

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailura. List only ona cluse on each line.

Approximate Intarval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in death)

a. Prostate Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

Abdominal Aortic Aneurysm

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, Steta)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, end due to tha cause(s) end menner stated.

29b. Signeture end title of certifier: George E. Wicks MD

29c. License number: D41365

29d. Date signed (Month, Dey, Year): November 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr George E. Wicks, MD - 9600 North Point Rd., Fort Howard, MD 21052

State Registrar

31. Date filed (Month, Dey, Year): NOV 07 2001

32. Registrar's Signature: Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-t show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

James Wallace Beckwith

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35476

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Estelle Baker

2. Date of Death Month Day Year: November 2 2001

3. Time of Death: 06 03 AM

4a. Facility Name *(If not institution, give street and number)*: Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: City

Funeral Director

5. Social Security Number: 219-28-0127

6. Sex: 1☐M 2☑F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12 12 31

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑Yes 2☐No

10e. Street and Number: 27 N. Charles St

10f. Zip Code: 21201

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Social Worker

16b. Kind of Business/Industry: Social Work

17. Father's Name *(First, Middle, Last)*: Isaiah Carter

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Kathleen Howard-Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1176 St. Agnes Lane Balto MD

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery

Date: 11-8-01

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: ▶ Patricia Betts

22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline St Balto. MD 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — Approximate Interval: 48 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other *(specify)* 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: metastatic carcinoma

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death *(Check only one)*: Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Kenneth A. Korzick MD

29c. License number: D40744

29d. Date signed *(Month, Day, Year)*: November 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.A. Korzick, MD Mercy Medical Center 301 St Paul Pl. Baltimore MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 07 2001

32. Registrar's Signature: ▶ D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM#7 per fh G801 110701 ss

Certificate of Death

Reg. No. 2001 35477

PATIENT KNOWN AS JUNE BOOKER

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): June Booker
2. Date of Death Month Day Year: November 2001
3. Time of Death: 18:52PM
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 219-20-5106
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-1-1926
9. Birthplace (State or Foreign Country): Md

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1190 W. Northern Parkway
10f. Zip Code: 21210
10g. Citizen of What Country?: U S A
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): Master's Degree
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Baltimore City
17. Father's Name (First, Middle, Last): Julius Strayhorn
18. Mother's Neme (First, Middle, Maiden Surname): Viola Johnson
19a. Informent's Neme/Reletionship (Type, Print): Brian Booker - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8500 Glen Michael Lane Randallstown, Md 21133
20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): Metro Crematory
Date: 11-7-01
20c. Location - City or Town, Slala: Catonsville, Md
21. Signature of Funeral Service Licensee: ▶ Hubert E. Bs
22. Name and Address of Facility: March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or haart failura. List only one causa on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)
a. Massive Myocardial Infarction
Due to (or as a consequence of):
b. Coronary artery disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Hypertensive cardio-vascular disease
Due to (or as a consaquence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signatura and title of certifiar: ▶ David J. Penn MD
29c. Licansa number: D0029928
29d. Date signed (Month, Day, Year): November 3d 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): David J. Penn MD, 1838 Greene Tree Rd, Pikesville MD 21208.

State Registrar

31. Date filed (Month, Day, Year): NOV 07 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35478

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAXINE B. BLACHOWICZ
2. Date of Death: Month November Day 4 Year 2001
3. Time of Death: 2035
4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-09-3479
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/30/17
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 815 OLDHAM STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINE OPERATOR
16b. Kind of Business/Industry: CROWN, CORK & SEAL

17. Father's Name (First, Middle, Last): CHARLES HUMES
18. Mother's Name (First, Middle, Maiden Surname): GARNET

19a. Informant's Name/Reletionship (Type, Print): MR. JOHN BLACHOWICZ
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 815 OLDHAM ST. BALTO., MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HOLY ROSARY CEME. Date: 11/7/01
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: ▶ Charles Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

		Approximate Interval Between Onset end Deeth
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	1 week
Due to (or es a consequenca of):		
Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last b.	Chronic Obstructive Pulmonary Disease	25 years
Due to (or as a consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings avelleble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, streel, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowtedge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signeture end title of certifier: ▶ Francis Jensen
29c. License number: D0056009
29d. Date signed (Month, Day, Year): November 4, 2001

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Frances R. Jensen MD Union Memorial Hospital Baltimore Maryland 21218

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: ▶ Jeanne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CPM
01-6174-510
01-303
Thomas Andrew
Bartowiak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 113001:ITEMS#23a,ptII,27 per ME 8801 ss

Certificate of Death

Reg. No. 2001 35479

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
THOMAS A. BARTKOWIAK, JR.	NOVEMBER 1, 2001	12:16 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2400 BLOCK OF SISSON STREET	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-96-1742	1☒M 2☐F	37 Yrs.			8/1/64	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
7006 EASTBROOK AVE.	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	0	LABORER	CONSTRUCTION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
THOMAS A. BARTKOWIAK, SR.	DIANE LIPSKY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
MR.&MRS. THOMAS BARTKOWIAK	7006 EASTBROOK AVE. BALTO., MD. 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	ST. STANISLAUS	11/7/01	BALTO., MD.

21. Signature of Funeral Service Licensee: Charles Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. NARCOTIC AND COCAINE USE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnent in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Dey Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end manner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
J Pestaner, M.D	O.C.M.E.	NOVEMBER 2, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
NOV 06 2001	Jeanne G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35480

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
FROMA GRESSER BERSHTEIN	NOV 3 2001	3:10 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6317 PARK HEIGHTS AVE #512	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-16-4574	1☐M 2☒F	78 Yrs.			NOV 1 1923	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6317 PARK HEIGHTS AVE # 512	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		TRAVEL AGENT	TRAVEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SAMUEL GRESSER	GUSSIE SMITH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. LAWRENCE BERSHTEIN/SON	8218 STONE TRAIL DRIVE BETHESDA, MD.20817

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MIKRO KODESH-BETH ISRAEL CONGREGATION	11/5/01	BALTIMORE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Scott M Cuttle	SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD.21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LIVER FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. metastatic colon cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Gwen L DuBowno MD	D30942	11/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gwen L DuBowno 2411 W Belvedere Ave Suite 504 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #15 PER FH G801 11/07/01 JH

Certificate of Death

Reg. No. 2001 35481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOAN Becker

2. Date of Death: Month NOV Dey 4 Year 2001

3. Time of Death: 0640

4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 105-28-1197

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 1, 1936

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD

10b. County: HOWARD

10c. City, Town or Location: COLUMBIA

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9777 EARLY SPRING WAY

10f. Zip Code: 21046

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): $ 4 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): BIOCHEMIST

16b. Kind of Business/Industry: BIOCHEMISTRY

17. Father's Name (First, Middle, Last): SAM ABRAMS

18. Mother's Name (First, Middle, Maiden Surname): CELIA WERNICOFF

19a. Informant's Name/Relationship (Type, Print): HILLARY BECKER / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10279 WINDSTREAM DRIVE COLUMBIA, MD 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): COLUMBIA MEMORIAL PARK

Date: 11/5/01

20c. Location - City or Town, State: COLUMBIA, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE — 5days

Due to (or as a consequence of):

b. PANCREATIC CANCER — 3months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: ▶ Edward J Reed MD

29c. License number: DZ3601

29d. Date signed (Month, Day, Year): NOV 4 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): 11065 Little PATUXENT PARKWAY, COLUMBIA MD 21044

State Registrar

31. Dete filed (Month, Day, Year): NOV 07 2001

32. Registrar's Signature: Jennie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. # 2001 35482

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Joseph William Cihlar	November 6, 2001	3:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3 Dunsinane Drive Apt. L	Nottingham	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-24-4826	1☒M 2☐F	73 Yrs.			6/22/1928	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Nottingham	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3 Dunsinane Drive Apt. L	21236	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1946-48	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Purchasing Agent	State of Maryland

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph John Cihlar	Alice Lappe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Irene Cihlar/Wife	3 Dunsinane Drive Apt L Baltimore MD 21236

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory	11/7/01	Baltimore, MD

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Coronary artery disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶	29c. License number	29d. Date signed (Month, Day, Year)
	D0035157	11/7/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Jeff Brown
9101 Franklin Square Drive Ste 104 Baltimore MD 21237

State Registrar

31. Date Filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	Bruce D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1041

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35483

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARLAND D. CASSELL

2. Date of Death: Month Nov. Day 3, Year 2001

3. Time of Death: 5:05 AM

4a. Facility Name (If not institution, give street and number): 5822 Forest Hill Road

4b. City, Town, or Location of Death: Elkridge

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 235-20-0777

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 10, 1923

9. Birthplace (State or Foreign Country): West Virginia

Usual Residance of Decedent

10a. Stete: Md.

10b. County: Howard

10c. City, Town or Location: Elkridge

10d. Insida City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5822 Forest Hill Road

10f. Zip Code: 21075

10g. Citizan of Whet Country?: USA

11. Meritel Stetus: 1 ☐ Nevar Married 2 ☐ Merried 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 ☒ Yas 2 ☐ No. If Yas, Giva Yaar or Detas: 1942-48

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.): 1 ☐ Yes 2 ☒ No Specify:

14. Raca - Amarican Indien, Black, White, atc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired): Truck Driver

16b. Kind of Businass/Industry: Trucking

17. Father's Nema (First, Middla, Last): Asa E. Cassell

18. Mother's Nama (First, Middla, Maiden Surneme): Vergie McLaughlin

19a. Informant's Name/Ralationship (Type, Print): Roger Cassell - son

19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code): 5822 Forest Hill Road, Elkridge, Md. 21075

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Othar (Specify)

20b. Place of Disposition (Nema of cematary, cramatory or othar place): Meadowridge Memorial Pk.

Date: 11/05/01

20c. Location - City or Town, Stata: Elkridge, Md.

21. Signature of Funeral Service Licensee: ▶ Mark K. Maulsby

22. Name end Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part1. Enter tha disaesa, or complications that caused the daeth. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or heert failura. List only ona cause on aach lina.

Approximete Intarval Batween Onsat and Deeth

Immediata Causa (Final diseasa or condition resulting in death)

a. PULMONARY Fibrosis — years

Dua to (or as a consequence of):

b. Rheumatoid Arthritis — years

Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in death) Last

Dua to (or as a consequence of):

c. COPD — years

Due to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☒ No

25. Was casa referred to medical examinar? 1 ☐ Yas 2 ☒ No

26. Placa of Death (Check only one): Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Rasidenca 6 ☐ Othar (Specify)

27. Mannar of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To tha best of my knowledge, daeth occurred at tha tima, data and place, end due to the cause(s) and mannar as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at tha tima, data and place, and due to the ceuse(s) and mannar stated.

29b. Signetura end title of certifier: ▶ Richard McCaleb

29c. License number: D31575

29d. Date signed (Month, Day, Year): November 5, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): KOLODNEY & 9501 Old Annapolis Rd Ellicott City MD 21042

State Registrar

31. Deta filed (Month, Day, Year): NOV 07 2001

32. Registrar's Signatura: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35484

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUSSELL BASIL LARLOCK
2. Date of Death (Month, Day, Year): NOVEMBER 1, 2001
3. Time of Death: 2:45 PM M
4a. Facility Name (If not institution, give street and number): 703 BERNADETTE DRIVE
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 183-12-9141
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 4, 1922
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: FOREST HILL
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 703 BERNADETTE DRIVE
10f. Zip Code: 21050
10g. Citizen of What Country? U.S.A.

To Be Completed by Funeral Director

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YRS; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINIST
16b. Kind of Business/Industry: BROWN CORK + SEAL CO.
17. Father's Name (First, Middle, Last): DENNIS LARLOCK
18. Mother's Name (First, Middle, Meiden Surname): STELLA JUSTINA LIBROWSKI
19a. Informant's Name/Relationship (Type, Print): M. KATHLEEN GREENE
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 320 BROAD RIVER DRIVE ANNAPOLIS, MD. 21401
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory, or other place): PARKWOOD CEMETERY
Date: NOV. 5, 2001
20c. Location - City or Town, State: PARKVILLE MARYLAND
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EVANS FUNERAL CHAPEL—BELAIR, P.A. 21030 3 NEWPORT DRIVE FOREST HILL, MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — 1 minute

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D34651
29d. Date signed (Month, Day, Year): NOVEMBER 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SCOTT S. HASLETT M.D. 2 NORTH AVE BELAIR, MARYLAND

State Registrar

31. Date filed (Month, Dey, Year): NOV 07 2001
32. Registrar's Signature:

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 10+1

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-6257-510

JAMES COPELAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35485

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Copeland

2. Date of Death Month/Day/Year: NOVEMBER 4, 2001

3. Time of Death: 8:07P. M

4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-56-4881

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 21, 1951

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2019 McHenry St.

10f. Zip Code: 21223

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 11 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receiver

16b. Kind of Business/Industry: Circular Advertising

17. Father's Name (First, Middle, Last): Joseph Copeland

18. Mother's Name (First, Middle, Maiden Surname): Grace Davis

19a. Informant's Name/Relationship (Type, Print): Mrs. Eileen Copeland (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2019 McHenry St. Balto. Md. 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion

Date: 11/12/2001

20c. Location - City or Town, Stete: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. RUPTURED Aortic DISSECTION

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of): b. Hypertensive Cardiovascular Disease

Due to (or as a consequence of): c.

Due to (or as e consequence of): d.

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnency 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Dete of delivery Month Dey Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted. 2 [X] Medicat Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. [illegible]

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Year): NOVEMBER 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): NOV 07 2001

32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CPM
01-6229-005
DARRELL CHEEKS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 111901:ITEMS#23a,27 per ME G01 SS

Certificate of Death

Reg. No. 2001 35486

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Darrell Cheeks			NOVEMBER 3, 2001	12:02 PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
GREATER BALTIMORE MEDICAL CENTER	TOWSON		BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-54-7022	1 X M 2 ☐ F	42 Yrs.			Jan. 14, 1959	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6508 Park Heights Ave.	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Postal Carrier	U.S Post Office

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Cheeks	Olivia Spruill

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
(mother) Mrs. Olivia C. Stewart	111 Hamlet Hill #1003 Balto. Md. 21210

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Garrison Forest	11/9/2001	Owings Mills, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Joseph L. Russ	Joseph W. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No	1 X Yes 2 ☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	NOVEMBER 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary G. Ripple MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 06 2001	Jennie B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Jane Colandro
2. Date of Death (Month, Day, Year): November 3, 2001
3. Time of Death: 10:48 P M
4a. Facility Name (If not institution, give street and number): 4120 Beachwood Road
4b. City, Town, or Location of Death: North Point
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-28-4838
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 14, 1934
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: North Point
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 4120 Beachwood Road
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Hockenberry
18. Mother's Name (First, Middle, Maiden Surname): Letitia Macneer

19a. Informant's Name/Relationship (Type, Print): Joseph Colandro (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4120 Beachwood Road, North Point, Maryland 21222

20a. Method of Disposition: ☒1 Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Grdns.
Date: Nov. 6, 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer - squamous cell — 4 months
Due to (or as a consequence of):
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
- Lupus
- Colon/rectal cancer
- Depression

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Michael Tyerman
29c. License number: D35761
29d. Date signed (Month, Day, Year): 11/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Johns Hopkins Bayview Medical Center, Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): NOV 07 2001
32. Registrar's Signature ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35488

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MADELINE M DAVIS

2. Date of Death: Month Nov Day 02 Year 2001

3. Time of Death: 2:30 P M

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-07-1994

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 2, 1914

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 607 Winters Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 College (1-4or 5+): 0

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Lab Technician

18b. Kind of Business/Industry: Federal Government

17. Father's Neme *(First, Middle, Last)*: James Middleton

18. Mother's Neme *(First, Middle, Maiden Sumame)*: Georgia Watson

19a. Informant's Name/Reletionship *(Type, Print)*: Mrs. Helen Tilghman (Friend)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 607 Winters Lane Balto. Md. 21228

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore National

Date: 11/8/2001

20c. Location - City or Town, Stete: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23e. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Immediete Cause (Finel disease or condition resulting in death)

a. Acute Renal Failure — Approximate Interval Between Onset and Death: 2weeks

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Acute Tubular necrosis — 2weeks

Due to (or as e consequence of):

c. Pneumonia — 2weeks

Due to (or es e consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnancy 4☐ Pregnent et time of death 5☐ Other *(specify)* 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart failure

Severe Chronic obstructive Pulmonary disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: B Lee Physician

29c. License number: D-52544

29d. Date signed *(Month, Day, Year)*: Nov 02, 2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Benjamin S. Lee, M.D. 700 Gerpe Rd #204, Catonsville, MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 07 2001

32. Registrar's Signature: Jennie D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35489

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roland Walter Douglas
2. Date of Death (Month, Day, Year): November 5, 2001
3. Time of Death: 11:20 p.m.
4e. Facility Name (If not institution, give street and number): Baltimore V.A. Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-42-0795
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 31, 1944
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2905 PRESSTMAN STREET
10f. Zip Code: 21216
10g. Citizen of What Country?: USA.

11. Maritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 9TH GRADE; College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): ASSEMBLY WORKER
16b. Kind of Business/Industry: GENERAL MOTORS

17. Father's Neme (First, Middle, Last): ROLAND DOUGLAS
18. Mother's Neme (First, Middle, Maiden Surneme): FLORENCE COLE

19e. Informent's Neme/Reletionship (Type, Print): MILBURN DOUGLAS (BROTHER)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 3004 ROSALIND AVE., BALTIMORE, MD. 21215

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Pleca of Disposition (Name of cemetery, crematory or other plece): CROWNSVILLE CEMETERY | Date: 11-9-01
20c. Location - City or Town, Stete: CROWNSVILLE, MARYLAND

21. Signeture of Funeral Service Licensee: [signature]
22. Name end Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory ertest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death):
a. Nonsmall cell lung cancer — 7 months
Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

HIV

Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicat examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [signature] MD
29c. License number: P15712
29d. Date signed (Month, Day, Year): November 5, 2001

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Adebisi M. Ajala, M.D., BVAMC, 10 N. Greene St., Baltimore, MD 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 07 2001
32. Registrer's Signeture: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
SOL	DRUSS	NOVEMBER 3 2001	2:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3417 GLEN AVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
262-44-1463 A	XX 1 M 2 F	87 Yrs.			MAR 8 1914	NEW YORK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3417 GLEN AVE	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: WW II	1 Yes 2 XX No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	SENIOR METHODS ANALYST	U.S. POSTAL SERVICE
	5 +		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MORRIS DRUSS	ANN DRUSS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. BRACHA GOETZ/DAUGHTER	3417 GLEN AVE BALTIMORE, MD. 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 XX Removal from State 4 Donetion 5 Other (Specify)	MT. HEBRON	11/4/2001	FLUSHING, NY.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive heart failure	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 X Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 **Madical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D30377	November 3, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert M. Cooper MD 6503 Park Heights Ave Balt MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35491

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ETHEL BAYNE DOUGLAS

2. Date of Death (Month, Dey, Year): OCTOBER 29, 2001

3. Time of Death: 3:43 PM

4a. Facility Name (If not institution, give street and number): SUNRISE ASSISTED LIVING

4b. City, Town, or Location of Death: GAITHERSBURG

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-40-6262

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 4, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 19310 Club House Road

10f. Zip Code: 20886

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): secretary

16b. Kind of Business/Industry: church

17. Father's Name (First, Middle, Last): William James Bayne

18. Mother's Name (First, Middle, Maiden Surname): Estella Schneider

19a. Informent's Name/Relationship (Type, Print): Michael Douglas/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4911 Bald Hill Rd Adamstown, MD 21710

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, Stete

21. Signature of Funeral Service Licansee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 10mts.

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b. Cardiac arrythmia.

Due to (or as a consequence of):

c. Pulmonary Embolism

Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier: Hieh. D. Khaney

29c. License number: D22978

29d. Date signed (Month, Day, Year): October twenty nine two thousand one

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): KHIANEY HIRU. D.

State Registrar

31. Date filed (Month, Day, Year): NOV 0 7 2001

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-6128-005
B.K.S
MILDRED ESLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 110901:ITEMS#23a,27,28a-f per ME G801 ss

Certificate of Death

Reg. No. 2001 35492

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED MARIE ESLER
2. Date of Death (Month, Day, Year): OCT. 30. 2001
3. Time of Death: 4:05 A M

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-05-4900
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 13, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8706 Baker Avenue
10f. Zip Code: 21234
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): medical secretary
16b. Kind of Business/Industry: private practice

17. Father's Name (First, Middle, Last): Joseph Lavicka
18. Mother's Name (First, Middle, Maiden Surname): Sophia Pich

19a. Informant's Name/Relationship (Type, Print): Eric Esler/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8706 Baker AVenue Baltimore, MD 21234

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACETAMINOPHEN AND PROPOXYPHENE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es a consequenca of):

c. Due to (or es e consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnent at time of deeth 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): Found: 10-29-01
28b. Time of Injury: Found: 5:00p M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject ingested drugs
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 8706 Baker Ave., Balto., MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Yeer): OCT. 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. R, PA LSW, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 0 7 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35493

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
BERNICE	FALK	NOV.2,2001	12:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOSPICE OF BALTIMORE - GILCHRIST CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-30-7976	1☐ M 2☒ F	69 Yrs.			JUN.29,1932	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8 TANNER COURT	21208	U.S.A.

11. Meritel Status	12. Wes Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Neme (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
LOUIS	BETTER	ANNA	TOSSMAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
IRVIN FALK / HUSBAND	8 TANNER COURT - BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Nema of cemetery, crematory or other piece)	Deta	20c. Location - City or Town, State
1☒ Buriat 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)	CHIZUK AMUNO ARLINGTON	11/4/01	BALTIMORE, MD

21. Signeture of Funeral Service Licensee ▶ Jay Falk

22. Neme end Address of Facility: SOL LEVINSON & BROS., INC. ~~8900~~ REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Deeth
Immedieta Ceusa (Final disease or condition resulting in deeth)	e. metastatic Adenocarcinoma of Lung	months
	Due to (or es a consequance of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yas 2☐ No

25. Wes cese referred to medicel examiner?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Menner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturaf 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) end manner as stated. 2☐ **Medicel Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and menner steted.

29b. Signatura and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	November 2, 2001

30. Neme and eddress of person who completed ceuse of death (Item 23e) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md. 21204

31. Dete filed (Month, Day, Year)	32. Registrer's Signeture
NOV 07 2001	▶ Bruce D Sparks

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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12:28pm 11/2/01 Bernice Falk 5 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #13 PER FH G801 11/15/01 JH

Certificate of Death

Reg. No. 2001 35494

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Angela D. Giacalone

2. Date of Death: Month NOV. Day 3 Year 2001

3. Time of Death: 4:33 AM M

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-58-1680

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR. 25, 1927

9. Birthplace (State or Foreign Country): Argentina

Usual Residence of Decedent

10a. State: MD

10b. County: Howard Co.

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 9232 Sewall Avenue

10f. Zip Code: 20723

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒Yes 2☐No Specify: ARGENTINEAN

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Juan Tonino

18. Mother's Name (First, Middle, Maiden Surname): Maria Alverez

19a. Informant's Name/Relationship (Type, Print): Nilda Bellagamba - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9232 Sewall Ave., Laurel, Md. 20723

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Cemetery

Date: 11/7/01

20c. Location - City or Town, State: Rockville, Md.

21. Signature of Funeral Service Licensee: ▶ Mark Marshall

22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, Md. 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

b. Emphysema

Due to (or as a consequence of):

c. Chronic Respirtory Failure

Due to (or as a consequence of):

d. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzhiemer's Disease

Dementia

Systemic Lupus Erythemetusis

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S Udapi MD

29c. License number: D21200.

29d. Date signed (Month, Day, Year): Nov. 3. 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shrinivas Udapi, MD 7245-B Hanover Pkwy., Greenbelt, Md. 20770

State Registrar

31. Date filed (Month, Day, Year): NOV 07 2001

32. Registrar's Signature: ▶ Regina B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

#13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35495

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
MATTIE	GLADNEY	11 / 2 / 01	8:45 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FOSTER CARE CITY	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-18-9570	1☐M 2☒F	87 Yrs.			12-31-13	S.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2519 ROSEDALE ST.	21216	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SUPERVISOR	GILL MANUFACTURING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SIMPSON YOUNG	CARRIE GINYARD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
AUDREY MONROE/NIECE	4403 KATHLAND AVE, BALTO., MD 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MD NATIONAL	11/7/01	LAUREL, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James A. Morton	JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cervical Cancer	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mike Lawrence MD	D51148	November 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mike Lawrence 821 N. Eutaw St St. 405 Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	Barbara P Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

CPM
01-6225-005
STEPHEN GREFFE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35496

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stephen Howard Greffe
2. Date of Death: Month NOVEMBER Day 3, Year 2001
3. Time of Death: 9:55 A M
4a. Facility Name (If not institution, give street and number): 4 LIBERTY DAM ROAD
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-60-8386
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 49 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-12-1952
9. Birthplace (State or Foreign Country): Hawaii

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3822 Walt Ann Drive
10f. Zip Code: 21042
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Developer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Howard James Greffe
18. Mother's Neme (First, Middle, Meiden Surneme): Phyllis June Greffe

19a. Informant's Name/Relationship (Type, Print): Philip Greffe / Brother
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3822 Walt Ann Drive, Ellicott City, Maryland 21042

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory
Date: 11/06/01
20c. Location - City or Town, Stete: Stevensville, Maryland

21. Signature of Funeral Service Licensee: ▶ Michele N Vetula 110141
22. Name and Address of Facility: Singleton Funeral Home, P.A.
1 Second Avenue, S.W. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. INTRA-ORAL GUNSHOT WOUND
Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or es a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of deeth 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☒ No 3 ☐ Probebly 4 ☐ Unknown PARTIAL

24a. Was an eutopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year): 11/3/01 FOUND
28b. Time of Injury: FOUND 0930 M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: SUBJECT SHOT SELF
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FIRING RANGE
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): MARYLAND STATE POLICE FIRING RANGE 4455 DAM ROAD, RANDALLSTOWN, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.
29b. Signature and title of Certifier: ▶
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Yeer): NOVEMBER 4, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIDDLE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 07 2001
32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35497

GENTILE, NAOMI

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Naomi	Marie	Gentile	NOVEMBER 4, 2001	2:20 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FRANKLIN SQUARE HOSPITAL	ROSEDALE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-16-5018	1☐ M 2☒ F	79 Yrs.			12/22/1921	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Edgewood	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1916 Juniper Road	21040	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Factory Worker	Catalog Sales

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Thomas Gray	Helena Mueller

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Phyllis Jean Swezey (Daughter)	2008 Longview Avenue Rosedale, Maryland 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Sacred Heart of Jesus	11/8 2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael C Jaffin M00938	Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PSEUDOMONAS SEPTICEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC IMMUNOSUPPRESSION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE, ASTHMA, CHRONIC STEROID USE, RENAL INSUFFICIENCY

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Lavanya Yarlagadda	P14559	NOVEMBER 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. LAVANYA YARLAGADDA 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #29d PER PHY G 801 11/07/01 DH

Certificate of Death

Reg. No. 2001 35498

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
GORDON	B.	GRIFFITH	OCTOBER	28,	2001	11:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7756 W.B.&.A. ROAD	SEVERN	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-38-1331	1☒M 2☐F	61 Yrs.					SEPT. 4, 1940	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	SEVERN	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7756 W.B.& A. ROAD	21144	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		POLICE OFFICER	STATE OF MARYLAND

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
ARTHUR	GRIFFITH	LOUISE	STALLINGS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BONNIE GRIFFITH (WIFE)	7756 W.B.& A. ROAD, SEVERN, MD. 21144

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒1 Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	FRIENDSHIP CEMETERY	11/1/2001	HANOVER, MD.

21. Signature of Funeral Service Licensee ▶ Pamela A. Hunter

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Embolism	hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification;

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ H Joseph Kim MD	D34480	10/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H Joseph Kim, MD 203 Hospital Drive, Glen Burnie, MD 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	Donna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 35499

GROSS, GERWIN

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
GERWIN	GROSS	November 03, 2001	00:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL 2401 WEST BELVEDERE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-12-4293	XX 1 M 2 F	83 Yrs.			OCT 17 1918	MD.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7618 LABYRINTH ROAD	21208	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+) 1	PACKAGING ENGINEER	AEROSPACE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SAMUEL GROSS	HILDA KLEIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. EVELYN R. GROSS/WIFE	7618 LABYRINTH ROAD BALTIMORE, MD. 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	BETH TFILOH CONG.	11/05/2001	WOODLAWN, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward C. Reed	SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METABOLIC ACIDOSIS	24 hrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. MULTIPLE ORGAN SYSTEM FAILURE	
	Due to (or as a consequence of):	
	c. CONGESTIVE CARDIOMYOPATHY	
	Due to (or as a consequence of):	
	d.	

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A Hamburger M.D.	RES 000	November 03, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADRIAN HAMBURGER SINAI HOSPITAL 2401 WEST BELVEDERE AVE. BALTO. MD.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 07 2001	▶ Donna D Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 35500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM F GILMORE SR
2. Date of Death (Month, Day, Year): NOVEMBER 4, 2001
3. Time of Death: 1130 AM

4a. Facility Name (If not institution, give street and number): HANOVER HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-16-5158
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 24 1923
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2405 TERRA FIRMA RD
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUTCHER
16b. Kind of Business/Industry: FOOD

17. Father's Name (First, Middle, Last): JAMES GILMORE
18. Mother's Name (First, Middle, Maiden Surname): MABLE MACK

19a. Informant's Name/Relationship (Type, Print): Louise Gilmore/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2405 Terra Firma Rd., Baltimore, Maryland 21225

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY
Date: 11-09-01
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles H. Pondl
22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	PULMONARY EMBOLISM	30 MINUTES
Due to (or as a consequence of): b.	PANCREATIC CANCER	1 YEAR
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD RESIDENT
29c. License number: P15881
29d. Date signed (Month, Day, Year): NOVEMBER 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KEVIN M. AUDLIN, MD 3001 S. HANOVER STREET BALTIMORE, MD. 21225

State Registrar

31. Date filed (Month, Day, Year): NOV 06 2001
32. Registrar's Signature: Geneva B. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

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